Uniform Comprehensive Assessment Tool (UCAT) Assessor Manual

PREPARED BY:

NOTES:

Table of Contents

NOTES:

LEARNING OBJECTIVES

This Manual provides step by step instructions for completion of Parts I and III of the Uniform Comprehensive Assessment Tool (UCAT) in order to:

- Use the UCAT manual as a resource when completing the UCAT
- Document member needs, goals, abilities, preferences, and resources
- Make appropriate clinical judgments for Health Assessment, Consumer (member) Supports, and Environment
- Identify how the assessment process fits into the broader goals for delivering long term care services and supports effectively (level of care and service plan implications).

INTRODUCTION

The Uniform Comprehensive Assessment Tool (UCAT) is divided into three parts:

Part I — Multipurpose form used for intake, screening and referral. Provides personal demographic data and financial information.

Part II — Screening and prioritization form. The Part II is no longer used and therefore is not part of this manual.

Part III — Comprehensive assessment used to collect data about the member to identify unmet needs; to determine potential to remain or live in a community based care setting; to assist with development of a plan of care that maintains and enhances supports already in place. The UCAT III is the foundation for determination and redetermination of medical eligibility. It is also the foundation upon which the service plan is built. Complete and accurate information and recommendations concerning a member's abilities, needs and preferences leads to appropriate program placement and comprehensive service planning; assuring the health and welfare of the member. The assessment includes:

*Physical Health *Mental Health

*Functional Abilities *Physical Environment

*Nutrition

*Supports available within the home and community

Part III also contains a Caregiver Assessment.

UCAT Principles

The Uniform Comprehensive Assessment Tool (UCAT) provides: a uniform method of gathering information for level of care, program and service planning; facilitates accurate and in-depth assessment of member needs; eliminates unnecessary duplication of assessments; and promotes sharing of information across programs and agencies. The concept of uniformity encompasses more than having all programs use the same form. While the UCAT I is completed by multiple agencies for intake/screening/referral and is basic in nature, all personnel administering any part of the UCAT III require mandatory training and certification to maintain the following principles:

Uniformity of the TOOL: The UCAT is a comprehensive planning instrument. By using the same form, assessor/case managers across programs are familiar with information gathered and its variable uses. Historic and demographic information that remains constant can be easily verified by different assessors without having to be repeatedly asked of the individual. To be objective, domains and scoring are standardized. Assessor professional judgment, plus subjective input by the member are included. When a member's level of care need is being assessed, he or she is evaluated against the same criteria as everyone else applying for the program or services. When service planning is done, the member is evaluated based on individual strengths and needs, both met and unmet.

Uniformity of TRAINING: All field personnel are prepared for their functions using the same curricula as others performing the same role. Multi-program trainings promote the shared uniformity concept as well as common language and understanding among professionals. Interdisciplinary instructor teams ensure participants receive appropriate and reliable content and the opportunity to view the assessment as a holistic process.

Uniformity of PERFORMANCE: Because of uniform training and ongoing performance evaluations required to maintain certification, like personnel administer the assessment uniformly in the field. Members with very similar situations should receive very similar UCAT scores. Subjective information from members and informal supports make individualized care plan implications obvious.

Uniformity of RESULTS: When administered uniformly, the UCAT generates accurate member information, individualized, yet comparable management data, and member-specific level of care and service plan implications- all of which are both useful and useable across service team/provider disciplines. In management- accurate, comparable utilization information is collected to plan future strategy, policy, funding and systems development. For providers- accurate, comprehensive and individualized data drives service planning and delivery. For members and the general public- confusion and fragmentation are reduced by promoting understanding and coordination for effective and efficient use of resources.

When assessor/case managers adhere to the UCAT principles, the UCAT is a vital tool for use in eligibility, service planning and management of services to individuals.

UCAT, the Form

The UCAT form has had several revisions over the years and has been formatted a number of ways. The most current paper/electronic version can be found at http://www.okdhs.org/library/forms/?category=aging. A Spanish version is also available at the site. The electronic data entry and retrieval system used by OKDHS, ELDERS, uses an electronic version of the UCAT that is somewhat different in sequence, ways of recording and appearance when printed, however *contains the same information* as the paper version. This manual generally reflects the step by step completion of the paper version and can equally be used by ELDERS assessors, recognizing a 'check' may be 'click' or a 'record' and visa versa.

UCAT as a Tool for Eligibility

Documentation within the UCAT is used by OKDHS and OHCA to establish an individual's level of care and eligibility requirements for care within a nursing facility or in the home setting. Home and community based services include: the State Plan Personal Care Program, AD*vantage* Waiver and the Medically Fragile Waiver. The tool must be completed in its entirety to allow for an accurate medical level of care determination. The initial UCAT for medical eligibility is completed by registered nurses employed with OKDHS and OHCA. Subsequent UCATs are completed at least annually by these same registered nurses or by certified case managers employed by contract provider agencies. Specially trained registered nurses within OKDHS and OHCA review the documentation against standard criteria and use professional nursing judgment to determine the most appropriate level of care program and service need of the individual. Refer to OAC 317:35-15,17,19 and 317:50-1 for specific medical eligibility criteria.

UCAT as a Tool for Assessor/Case Managers

Assessor/case managers are responsible for updating the UCAT upon receipt of a referral and throughout member monitoring. The UCAT is re-administered by assessor/case managers annually for level of care redetermination and service plan reassessment or on an as needed basis—whenever the member experiences a significant change to his/her health and/or welfare. The UCAT provides the information from which the service plan and goals are developed. As evidenced in research, *individualized* care is the most cost-effective and successful approach to support nursing facility level of care in the home. Plans of care that address an adequate response to a member's unmet needs influence the success of home and community based services in improving older adults and adults with disabilities ability to remain in the community. The case manager translates the UCAT information into a package of services, both formal and informal, designed to maintain the health and safety of the member. Reference also OAC17:35-17&20 and 317:30-5-(760-764), all contractual documents associated with the program including but not limited to Conditions of Provider Participation and Service Standards.

UCAT as a Tool for Service Plan Authorization and Clinical Review

Documentation within the UCAT is used by OKDHS and OHCA to justify authorization of services requested on the service plan and goals. It allows a clearer determination that service and care plans submitted by case managers adequately, appropriately, effectively and efficiently meet and do not exceed the unmet needs of the member to remain healthy and safe within the community. Services included on the service plan but not related to evidence and recommendations made on the UCAT require justification from the case manager prior to authorization. **NOTE:** Different programs use the words 'service plan', 'care plan', 'plan of care' and 'goals' somewhat differently to refer to the documents that reflect services and costs as well as action steps related to services. These terms may interchange within the UCAT Assessor Manual and refer to some or all of the above.

The UCAT Manual

The UCAT manual includes instructions for completing each question of the UCAT. The manual also provides **Service Plan Implications** to prompt the assessor/case manager to consider what additional questions need to be asked to gather complete and comprehensive information. Additionally, **Level of Care Implications** are provided to assist the assessor/case manager to make appropriate service option recommendations based on appropriate documentation of the member's current situation.

Annual Reassessment

Waiver policies require assessor/case managers to re-administer and submit a new UCAT Part I and III annually. The UCAT is updated throughout the year to reflect changes in health and functional status, needs, resources, or any significant event that impacts a member's health and welfare. Annual reassessment is not a requirement of State Plan Personal Care or Nursing Home service.

UCAT Assessor Evaluation Tool

The UCAT is a comprehensive document. The UCAT Assessor Evaluation Tool is used by OKDHS to certify that OKDHS nurses demonstrate the skills to complete a UCAT for medical eligibility. It is also a useful tool for other assessor/case managers. Although it doesn't evaluate the quality of service plan implications, it can assist new assessor/case managers in assuring all questions have been addressed as instructed.

UCAT Completion Tips

1. Expect a Learning Curve

Skills and abilities with UCAT completion improve with experience.

2. Don't Let the "form" limit you

The more accurate and complete the documentation by the assessor/case manager and the more thoughtful the implications, notes, and summaries, the more likely services will be identified and delivered in the most effective way to meet a member's needs. Using phrases like, "member may benefit from…" or "may wish to explore…" allows the assessor/case manager to share their expertise and knowledge of community resources which will be helpful at the Interdisciplinary Team (IDT) meeting. Remember to handle all confidentiality issues appropriately according to HIPAA regulations. Exclude extraneous information that has no bearing on level of care and service planning.

3. Use the UCAT as a monitoring and ongoing assessment tool

Assessing the needs and evaluating the effectiveness of the service plan are ongoing activities that occur every time an assessor/case manager has contact with a member. Updating the UCAT as a member's needs change can help the assessor/case manager in several ways. Applicable updated sections of the UCAT are attached to a service plan amendment to justify the changes. An updated UCAT assures the assessment is an accurate reflection of the member's current situation when a case is transferred to a new assessor/case manager. Moreover, maintaining an updated UCAT simplifies the annual reassessment.

4. Personalize All Documentation

Use the member's name as opposed to referencing "the member". Using a person's name and "people first" language demonstrates respect and can help an assessor/case manager from becoming desensitized.

5. Use caution when searching Web sites for health information and referral sources to include in or interpret findings from the UCAT

The UCAT process will often lead to a need for additional information. Always consider the **source** of information found on Internet Web sites. Know who developed and runs the site. Sites managed by the Federal Government, non-profit institutions, health systems and professional organizations are likely to be the most reputable. Focus on **quality** information. Look for **evidence**. Evidence based practice leads to best results for you and the member. Check for most **current** information. Beware of **bias**. Protect **privacy** of the member.

NOTES:

UCAT Part I

Assessor/Case Managers & UCAT I

During the initial visit
Assessor/case managers verify and update the information on Part I.

Ongoing
Assessor/case managers update the information on Part I whenever the information changes (i.e., address, physician).

Reassessment
Assessor/case managers complete a new Part I annually as a regular part of the reassessment process.

NOTE: Any changes in demographics are forwarded to the affected partner(s) as they occur.

The ELDERS version of the UCAT Part I includes the same information, however, the sequence and formatting may appear somewhat different.

UCAT Part I Intake and Referral

1. Indicate Use of Form

More than one item may be indicated as the form is used in a progressive manner. Remember, this item reflects how you are using the form.

2. Date

Enter the date of completion beside the process in item #1 to indicate when it took place.

3. Original Intake Referral Source

Enter the name, agency, or source and the telephone number of the source that originally referred the member. Sometimes more than one referral source has been involved, for example, both a family member and a home health agency has referred the member. In such cases, the home health agency and contact person are entered in #3.

4. Member's Name

Enter the member's name, beginning with the last name, followed by the first name and middle initial.

5. Member's Social Security Number/Case Number

Enter the member's Social Security number. If the member is unsure of the number, ask to see the Social Security card and enter the number. Enter the existing Medicaid number on the Unique ID Number line.

6. Member's Address

Enter the address at which the member currently resides and may receive mail. Be sure to capture the mailing address if this is different from the physical address.

Level of care implications: Prior to making a level of care determination, target population criteria must be met. To receive long term care services in Oklahoma, the applicant must be residing in the State of Oklahoma with intent to remain at the time medical service is rendered.

7. Member's County

Enter the county in which the member resides.

8. Member's Date of Birth

Enter the member's date of birth.

Level of care implications: Prior to making a level of care determination, target population criteria must be met. Some programs require age limitations for eligibility.

9. Member's Telephone Number

Enter the member's telephone number, including the area code, using the number at which the member can be reached. Indicate if this is a message only number.

10. - 13. Source of Information Other Than the Member

Complete the items in this section if someone other than or in addition to the member has provided the information.

10. Source's Name

Enter the name of the source of information.

11. Source's Telephone Number

Enter the telephone number, including the area code of the source.

12. Source's Address

Enter the address of the source.

13. Source's Relation to Member

Indicate the source's relationship to the member. If the source is a family member or "other," specify the relationship in the space provided. Hospital discharge planners or home health agency staff are frequent sources of referral information. Enter both the individual's name and the agency in such cases.

14. Member's Knowledge of the Call

Ask the source whether the member is aware of this call or assessment interview. Please check this item "yes" or "no" for each intake indicating member's knowledge of call. Unless the member has serious cognitive impairment, he/she should always be aware a request for services is being made.

15. Member Needs

Ask the member (or source):

"What problems are you having right now that are causing you difficulty? - or - What do you want us to assist you with?"

List any difficulties or problems that the member (or source) states are presently causing difficulty. If this form is being completed by phone, this is probably one of the first subjects you will discuss with the member.

Establish rapport with the member/caller during the discussion.

Determine whether the problem is a recent development. If so, determine whether the situation is critical and whether the member perceives the situation to be a crisis.

Ask the member (or source):

"How long have you had these needs?"

If the problems have been present for a significant time period, how has the member been managing?

Ask the member (or source):

"What services are you currently receiving?" Determine whether the member is receiving any formal services to help manage present problems. This information is important in helping you establish contacts with which to begin networking with other agencies, and in helping you determine appropriate or inappropriate referrals.

Ask the member (or source):

"What program or services are you requesting?"

16. Member's Marital Status

Indicate married, single, never married, divorced or separated, widowed,

or unknown

17. Member's Residence

Ask the Member (or source):

"In what type of residence do you live?"

Next to the appropriate space, indicate the type of residence in which the member resides. If the member doesn't understand or can't explain, describe the residence types listed. Complete this question only if the member lives in a private residence. Examples of private residences include a house, apartment, mobile home, etc. but do not include licensed facilities such as Residential Care Facilities, Group Homes and Nursing Homes.

Level of care implications: Prior to making a level of care determination, target population criteria must be met. Home and community based programs are not available to persons living in an institution, room and board, licensed residential care facility or *most* assisted living facilities. NOTE: AD*vantage* may include assisted living as an approved service within the plan of care.

18. Household Composition

Complete this question only if the Member lives in a private residence. Examples of a private residence include a house, apartment, mobile home, etc., but do not include licensed facilities such as: Residential Care Facilities, Group Homes, and Nursing Homes.

Ask the member (or source): "Do you live alone or do you live with others?"

Indicate the household composition in the appropriate space.

Use white spaces to note any information on household members that is offered, such as the relationship to the member, the level of support provided, and financial status. You can use this information to evaluate the strength/weakness of current support systems already in place for the member.

Level of care and Service Plan implications: The composition of the household is important in assigning appropriate hours of services for such things as ADL's and IADL's. It is also a key question for health and safety planning and should trigger further prob ing with questions like: "How are others in the household contributing to the member's care? Is the member providing care to others? Does this member require 24/7 supervision? If so, is it being provided? If it is needed and is not being provided, are there resources and supports available?" The service plan needs to address these issues as part of risk management planning to assure the member's health and welfare in the community. The presence of other persons within the household receiving HCBS or a Personal Care Attendant within the household affects service planning and must be noted.

19. Homebound Status

In the appropriate space, indicate whether or not the member is homebound. A homebound member is one who is unable to leave his/her residence unassisted by another individual.

Service Plan implications: Knowing whether a member is homebound or not has certain service plan implications. For example, it may mean the person is eligible for certain Medicare services. It should also stimulate your thinking: "how does a person leave his/her house? Who assists them? Why are they homebound? Is it permanent?" The answers to these questions will be reflected in the service plan.

20. Member's Primary Doctor, Other Doctors

Ask the member (or source) the following questions: "Who is your primary doctor?"
"Are you seeing any other doctors or specialists of any kind?"

Record primary and secondary physician's name, address (including city and zip), and phone number (including area code) in the space provided. Be sure to include all secondary physicians.

If the member does not know who his/her doctor is, note this and go to the next item.

Service Plan implications: Knowing the member's primary physician provides the assessor/case manager with a formal support to seek assistance from when significant changes or needs occur with the member. The primary physician can assist with recommendations for needed therapy, durable medical equipment, skilled nurse needs, etc..

21. Member's Legal Guardian/Power of Attorney

Ask the member (or source): "Do you have a legal guardian or someone with power of attorney?"

Record the member's answer. If the member has more than one legal representative, record the names, addresses, phone numbers, and relationships in the space for additional comments and note where you have written the information here.

If the member indicates that he/she has given power of attorney to another individual, enter that person's name, address, relation to member, and telephone number in the space provided. If the member indicates that he/she does not know, enter "Doesn't know" in the space provided.

Service Plan implications: Remember, if a member is represented by a legal guardian or power of attorney, that person should be a part of service planning and discussions. Often the guardian/power of attorney actually signs legal documents for the member. As a assessor/case manager, you will want to definitively establish the level of responsibility assigned to the guardian/power of attorney. You will also want to obtain a copy of the legal document that confirms his/her role as guardian/power of attorney, and make it part of the member's file and review it on an annual basis.

22. Emergency Contact

Inform the member that it is necessary for us to have an alternative contact in the event that we are unable to reach him/her or if further contact reveals an emergency or crisis situation that requires immediate attention.

In the space provided, record the name, address, relation to member, and telephone number of one or more local emergency contacts who live outside the member's present home. **This information must be kept up to date and accurate for as long as the member is receiving services.**

23. Member's Next of Kin

Indicate the name, address, relation to member, and telephone number of the member's next of kin.

Service Plan implications: Does the member have an emergency contact and/or next of kin? If none have been identified, this is a possible indicator of a weak or inadequate informal support system. Assisting the member in identifying and/or developing support systems should be included on the service plan.

24. Member's Income Sources

Ask the member (or source): "Do you receive income from any of the following sources?"

Read each source to the member as indicated on the form (a through j).

Ask the member (or source):

"Do you receive income from a source other than these I mentioned? If so, what is that source?"

Enter the member's response and dollar amount of the source.

Add all income source amounts, and enter the total next to the space labeled "Total income". Confirm this amount with the member. If there is a discrepancy with the member's statement, inquire about additional income sources that may not have been discussed.

Service Plan implications: The assessor/case manager is instrumental in assisting the member to submit required paperwork to OKDHS for financial eligibility determination and redetermination.

25. Assets

Explain that some programs use financial eligibility criteria that include assets other than a home or automobile. Example: OKDHS analyzes assets in its eligibility criteria. If the member does not wish to disclose information, it will be difficult or impossible to screen for OKDHS eligibility.

Explain to the member that assets include savings accounts, stocks, bonds, certificates of deposit, life insurance with cash value, anything held in trusts, etc.

Enter the member's estimated value of his/her assets, (excluding home and automobile) including anything of value transferred, given away, or sold in the last 3 - 5 years depending on the type of asset.

Detached Property - Property beyond the land where the member residence is located is considered an asset.

When only one individual in a couple who live in their own home is applying for waiver services, income and resources are determined separately. However, the income and resources of the individual who is not in the program is included on the application form. (refer to OAC policy for further clarification OAC 317:35-17 and 317-50-1).

Service Plan implications: The assessor/case manager is instrumental in assisting the member to submit required paperwork to OKDHS for financial eligibility determination and redetermination. Do not tell an applicant he/she is/isn't financially eligible. It is the role of the OKDHS Family Support Worker to determine financial eligibility.

26. Veteran Status

Ask the member (or source):

"Are you a veteran or spouse of a veteran?"

Enter response.

27. Member's Health Insurances

Ask the member (or source):

"Do you have the following (insurance coverage)?"

Read the various health insurance coverage as indicated on the form.

Indicate the appropriate choice beside each source of health insurance coverage.

Service Plan implications: Understanding and evaluating services available to the member is key to service plan development. Does the member have Indian Health benefits? VA benefits? Medicare? Other insurance? Is the member eligible for State Plan Personal Care Services? Remembering that waivers are the payor of last resort excluding from consideration existing Ryan White CARE Act and Indian Health Services, all possible available resources to the member should be considered and exhausted. The plan developed for the member will reflect use and coordination of benefits. Waiver services are explored when there are no other resources to accommodate a member's need. Efficient coordination of resources comes with experience. To gain knowledge, regular communication with your agency supervisor is suggested.

28. Work History

"What type of work did/do you do?"

This helps determine life skills or experiences.

29. Member's Education

Ask the member (or source):

"What grade did you complete in school?"

This answer may help explain answers or responses that result from lack of knowledge rather than medical or cognitive issues.

30. Member's Sex

This is a boxed item, not addressed to the member unless absolutely necessary. Indicate the member's sex as either male or female. If the sex is not readily discernible from the member's voice, use the member's name, with the appropriate prefix (i.e., Mr. Mrs. Ms.) during the conversation to confirm sex.

31. Member's Race/Ethnic Background

Ask the member (or source):

> "In regard to race, would you say you most closely identify with a White, Black/African American, Hispanic, Asian/Pacific Islander, or Native American/Alaskan?"

Read all the racial and ethnic background categories to the member that are indicated on the form.

Ask the member to select one of the race/ethnic background categories.

Indicate member's response in the appropriate space. Do not use the "other" category for combinations of White such as Irish, German, etc. Use "other" only for combinations of the various race/ethnic categories. If the member states he/she is Native American, ask if he/she has a CDIB (Certified Degree of Indian Blood) card.

Mistakes are sometimes made when the assessor assumes the member's race. Therefore, this question is structured to allow the member to determine the answer.

32. Member's U.S. Citizenship/Legal Residency and Country of Origin

Ask the member (or source):

> "Are you a U.S. citizen or a legal resident?"

If the member's response is "no", ask for his/her country of origin, and indicate the response in the space provided. Citizenship and Alienage verification is required via the *Immigration and Naturalization Service Identification Card.*

Level of care implications: Prior to making a level of care determination, target population criteria must be met. To be eligible for long term care in Oklahoma, the applicant must be a citizen or lawful permanent resident for 5 years or more.

33. Member's Primary Language

If there are no communication difficulties with the member because of language barriers, indicate English as the primary language.

If language barriers present difficulties during the conversation, determine the member's primary language, and indicate as such in the appropriate space.

If the member's primary language is not English, determine whether the member is able to speak and understand English and indicate as such in the appropriate space. If communication in English is a problem for the member, make an alternate arrangement for effective communication, such as enlisting the aid of an interpreter service.

If the member is significantly hearing or visually impaired or unable to speak, describe member's method of communication. This item is an opportunity to document information about communication challenges.

34. Referrals

Use this information to document any referrals you make after the Applicant Information section is completed, whether in-house or to outside agency/program's).

Record the date you make the referral.

List the services for which the member is being referred (e.g., homemaker, supportive/ restorative assistance, etc.).

Record the agency/program name to which you make the referral.

Specify the name of an individual at the referral agency who should be contacted for follow-up on the referral disposition.

35. Directions to Member's Location

Indicate directions that other persons can easily use when going to the member's location. Be as specific as possible.

Additional Comments/Information

This space is provided for the assessor to note any additional information received during intake, i.e., member's situation appeared dangerous, referred to Adult Protective Services (APS); member has co-guardians: list names, addresses, etc. If there is knowledge of a speech or hearing impairment (e.g., let phone ring at least 30 times); if member fears strangers and a family member should be contacted before the home visit; if pets need to be put up before your visit. In other words, any information that will assist the assessor/case manager can be written in this space.

Signature

Person completing Intake, Agency Name, Telephone Number. Be sure to print to ensure the new reader can identify you. Sign below printed signature and indicate date signed.

UCAT Part III

Assessor/Case Managers & UCAT III

During the initial visit
The initial UCAT III is completed by the OKDHS or OHCA Nurse.

Prior to the first visit, the assessor/case manager reviews the initial UCAT III.

Ongoing
Assessor/case manager updates the information on the Part III with any significant changes and submits to the Administrative Agent with initial and addendum service plans.

Reassessment
Assessor/case manager completes a new Part III annually as a regular part of the reassessment process.

The ELDERS version of the UCAT Part III includes the same information, however, the sequence and formatting may appear somewhat different.

Introduction

The UCAT III begins the comprehensive portion of the member assessment process. Assessment information is collected through a face-to-face interview with the member and contact with other reliable sources. Before asking the assessment questions, review and update information collected in the UCAT Part I.

Accurate and comprehensive assessment information forms the basis for appropriate program or service placement, service plan development, implementation, monitoring, and documentation. The UCAT Part III provides a systematic, standardized and multidimensional approach to collecting data about the member's physical health, functional abilities, social supports, mental health, and physical environment. Part III also contains a caregiver assessment. Effective case management requires assessor/case managers to understand the significance of each of the seven (7) domains, and how to recognize the service plan development, implementation, and monitoring implications of the assessment domains.

Title	Purpose
Mental Status Questionnaire (MSQ)	Measures the member's cognitive abilities
Health Assessment	Provides details pertaining to the member's health conditions, nutrition, medication usage, and alcohol and tobacco usage
Functional Assessment	Provides assessment of the member's ability to perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs)
Member Support and Social Resources Assessment	Provides details of the sufficiency of member support and identifies the strengths and any gaps or challenges in the current resources
Mental Health Assessment	Assesses the member's mental health status and the impact the status may have on his/her health and welfare
Environmental Assessment	Examines the safety and accessibility of the member's physical environment
Caregiver Assessment	Provides details of the member's informal caregiver response and caregiving potential.

Further Questions

Throughout the interview process, it is important to keep in mind that the information obtained potentially impacts level of care determination and the comprehensiveness of the service plan. Be prepared to question beyond the UCAT form and manual questions in order to identify all service plan and eligibility implications.

Other Sources

It is assumed the member is the primary source of information. If the member is medically, physically, or mentally unable to participate in some or all of the interview the assessor/ case manager will need to specify if interview responses are the member's or from another source. Other reliable and knowledgeable sources may include caregivers, family, friends, neighbors, etc. In addition, medical records may provide pertinent assessment information.

Assessor/Case Manager Observations

Assessor/case managers also use observation and clinical/professional judgment in completing and analyzing the UCAT information.

Valuable Information

Prior to beginning the UCAT interview, assessor/case managers will want to take time to establish rapport with the member and/or caregiver. The likelihood of gathering valuable information is higher when the member feels comfortable and safe with the assessor/case manager, therefore resulting in a better understanding of the member. This understanding will help the assessor/case manager direct the conversation and know when to ask additional questions.

Assessment Information

1. **Member Name**

   Enter the member's name, beginning with the first name, followed by the middle initial and last name and date.

2. **Member Social Security Number and Case Number**

   Enter the member's social security number, and any applicable program case number or Medicaid number(s).

3. **Location of Assessment/Reassessment**

   Indicate the location of the assessment interview in the appropriate space.

Mental Status Questionnaire (MSQ)

Introduction

The Mental Status Questionnaire (MSQ) assessment is a standardized screening for cognitive functioning. The MSQ is generally administered at the beginning of the Comprehensive Assessment so a member with cognitive impairments may be identified early in the process. You may choose to give it at a later time, depending on various circumstances.

NOTE: Assessors using the ELDERS format of the UCAT III need to read the instruc tions in ELDERS carefully prior to answering. The questions are posed the same, however, *the way the assessor documents the answer is somewhat different.* For example ELDERS asks for the assessor to indicate a month stated in error by recording a 'yes'. The paper UCAT version asks the assessor to indicate a month stated in error by recording an 'x''. The resulting score is the same when the instructions are followed correctly.

Administration

The purpose of the MSQ is to describe the member's cognitive functioning. Prior to beginning the MSQ, always inform others present that only the member is allowed to respond to this section of questions. If someone other than the member attempts to answer the MSQ questions, politely remind him/her and redirect the question to the member again.

The questions on the MSQ frequently result in anxiety for the member. He/she may feel capacity is being challenged or judged. Assessor/case managers can help ease the tension with the following techniques:

Establish rapport before starting the MSQ.

Explain that the MSQ is part of the overall assessment given to all members to help identify any services that will support their independence.

Don't confirm that answers are ''right'' or ''wrong''.

Members will notice when you are not writing on the form, so be sure to follow the instructions for marking all the answers.

Since every answer the assessor/case manager gives as prompt is scored as a wrong answer, use prompting only after member has been given ample time to respond.

If a member is answering questions easily and makes what appears to be a careless error, either ignore the error or ask the member to repeat the answer.

If the member remembers a correct answer at any time during or after the MSQ

assessment, score it as a correct answer and change the previous incorrect entry.

4. MSQ

Begin the questions with an opening statement such as:

"I am going to read you a list of questions. These are often asked in interviews like this, and we ask them the same way to everyone. Some may be easy and some may be more difficult for you. Let's start with the current year."

Enter answers beside each item. Do not try to calculate the total weighted score until after the MSQ is completed.

Complete MSQ assessment questions as follows:

Ask the member:

"What year is it now?"

Enter the member's response.

Ask the member:

"What month is it now?"

Enter the member's response.

At this point, tell the member:

"I will give you a phrase to memorize and will ask you to repeat it later on in the test."

Read the memory phrase to the member and have him/her repeat the phrase three times to try to commit it to memory. Tell the member again:

"I will ask you to repeat it again later."

NOTE: If memorizing the phrase appears entirely too difficult for the member proceed to Item C.

Ask the member:

"Without looking at a clock (or your watch), about what time is it?"

Enter the current time and member's response. In order to be correct, the member must give you the time within one hour of the correct time (one hour before or one hour after).

Tell the member:

"Count backwards from 20 to 1."

Indicate any missed numbers in the appropriate box on the form, and use this information for scoring this item later. In order to be correct, the member must start with 20 and count backwards to 1 without skipping any numbers. Numbers stated out of sequential order are considered errors.

NOTE: In order to avoid making it obvious when the member has missed an item, be sure to make an entry for correct answers as well as incorrect answers. (The member may become anxious if you mark only incorrect items, as opposed to marking all items.)

Tell the member:

"Say the months in reverse order."

For ease in scoring, ask the member to begin with the month of December. However, the member may begin with another month (e.g., current month) as long as he/she does not skip months. Be sure to make an entry for correct answers as well as incorrect answers. Use this information for scoring this item later.

Tell the member:

"Repeat the memory phrase that was given to you earlier." Enter

the member's response.

Service Plan implications: Cognitive impairment may signify the need to identify a higher level of informal support in the service plan. Is it safe for the person to stay alone overnight? If the answer is no, the plan should identify who will provide overnight supervision and how often. Can the person remember to take his/her medications? How much assistance is needed to ensure medications are taken properly? Indicate in the plan if a family member is going to fill a med box, for example. Is a daughter going to give medications? Maybe skilled nursing services will be required to set up medications and monitor. As an assessor/case manager, you should take into account the cognitive awareness of the member when developing the plan. Consider how the member's mental capacity affects all areas of his/her life and if it does, how you will address that in the plan.

How to Calculate Total Score

Obtain the number of scored errors for each item.

Multiply each score by the weight given for that score.

Add the weighted scores to obtain the total weighted error score.

Maximum score possible = 28

Use the following grid as a guide for scoring.

Scoring the MSQ

Question	Score		Weight	Max Score
What year is it now?	Correct =0	Incorrect or Doesn't know = 1	x4	4
What month is it now?	Correct =0	Incorrect or Doesn't know = 1	x3	3
About what time is it now?	Correct =0 (within one hour)	Incorrect = 1	x3	3
Count backwards from 20 to 1	No errors=0	One error =1 Two or more errors =2	x2	2 4
Say the months in reverse order	No errors=0	One error =1 Two or more errors =2	x2	2 4
Repeat the memory phrase	Correct=0	One point for each incorrect or missed item (Maximum 5)	x2	24 68 10

Use of MSQ Scoring Information

Research conducted with this mental status questionnaire indicates that a score of 10-12 or more is often consistent with dementia, but it is not a diagnosis. Many factors including education level, hearing loss, medications, pain, and fatigue can skew performance on the MSQ. The assessor/case manager needs to consider an additional source of information when the member scores 10 and must obtain collateral information for a score of 12 or greater. If that person is not in the home, it is important not to make the member uncomfortable by abruptly ending the interview. The assessor/case manager can continue with the assessment and when the member has difficulty with the questions, suggest rescheduling when someone is available to assist. Additionally, the following questions can serve as a guide to ask the member with a high MSQ score, leaving the remainder of the interview for a reliable source:

Section	Question
Health	
9	How do you remember to take your medications?
16	How is your appetite? Would you say that your appetite is good, fair, or poor?
19	Do you have any problems that make it difficult to eat?
22	Briefly describe what you usually eat and drink during a typical day (including week-ends). Specify any self-imposed diets or religious requirements.
23	Overall, do you consider your health as excellent, good, fair, or poor?
Social	
5	If you could not continue to live in your present location, do you have any thoughts about where you would like to live?
6	Is there a person you can talk to when you have a problem?
10	What activities or interests do you enjoy?
11	Are you able to attend services or practice your religion as often as you like?

Service Plan implications: When the MSQ is high and the member lives alone and/or is currently being left alone, the care plan must include the role of informal supports in providing safety supervision. Additionally, the MSQ along with other information gathered is necessary to determine IF a plan of care can be developed to sufficiently meet health and safety needs. If health and safety is in question, especially at times formal services are not present in the home, the case manager needs to discuss this with his/her supervisor and then with the Administrative Agent (OKDHS, OHCA).

Assessor Override

As with any scored section of the UCAT, whenever the assessor/case manager feels the MSQ score does not accurately reflect the member's ability, it can be re-administered at a later date or an assessor override can be used.

An assessor override allows the assessor/case manager to choose a score he/she feels is more appropriate. If a member is unable or unwilling to respond, the assessor/case manager can use professional judgment to assign a score. The override requires written justification and supervisory approval and can be documented on the UCAT form or added as an attachment.

Service Plan implications: When a member has a high MSQ and there is no other evidence within the UCAT of confusion, forgetfulness, etc., an explanation must be given. Documentation by the assessor/case manager of aphasia, education limitations etc. is important *along with* statements that the person is still able to function independently in his/her home will prevent potential delays in service authorization.

Sources of Information for the Assessment

Every effort should be made to use the member as the primary source of information for completing the assessment. However, if the member is cognitively impaired or otherwise medically or physically unable to participate in the assessment interview, another source may be used for much of the assessment.

Other sources of information about the member include anyone who is reliable and knowledgeable of the member's abilities and challenges. However, keep in mind that the more aware the informant is of the member's medical, mental and physical limitations, the more accurate your assessment information will be. **Remember to handle all confidentiality issues appropriately according to HIPAA regulations.**

A typical source may include:

- Caregiver or service provider. This is the individual who takes care of most of the member's needs or pays someone else to take care of the member. It could be a care facility operator, a sitter, a personal care aide, family members, etc.
- Family member
- Anyone who can **legally** provide medical records: any agency, hospital, or doctor
- Friend or neighbor who is concerned and frequently looks in on the member
- Any organization involved with member's care: home-delivered meals staff, visiting nurses, etc..

Health Assessment

There are 25 areas to complete in the health assessment section.

1	Source of Information
2	Health Conditions
3-6	Drug, Alcohol and Tobacco Use
7-10	Medication Use/ Pharmacy Information
11-12	Medical Utilization/ Institutional Admissions
13	Special Equipment/Assistive Devices
14	Medical Treatments and Therapies
15	Diagnosis
16-22	Nutrition
23	Subjective Evaluation of Health
24	Speaking/Communication
25	Clinical Judgment/Risk level/Comments & Service Plan Implications

Introduction

The Health Assessment provides detailed information about a member's current and past health conditions, nutrition, medication usage, medical service utilization, medical treatments, medical equipment requirements, as well as drug, tobacco and alcohol usage. Obtain the information directly from the member in a face-to-face interview. An additional source may be needed in some situations when the member is unable to provide the required information. If the assessor/case manager has access to the member's health records, information from the records can be transferred to the Health Assessment and verified during the interview with the member. The information obtained in the Health Assessment is used by the assessor to determine a health risk score for level of care determination and by the case manager for service planning and disease management.

Disease Management Basics

The importance of disease management is being realized as the population of the US ages and the incidence of chronic illnesses increases. Disease management involves not only interventions or treatments, but also education of members to participate in the day-to-day management of their health conditions. Disease management is a proactive and comprehensive approach to health care, resulting in improved member outcomes and member perceived well-being and satisfaction. If any chronic conditions have been identified during the comprehensive assessment, then disease management planning must be included in the service plan.

The member, assessor/case manager, and RN participate in detailed disease management planning and monitoring. When using the information from the Health Assessment for IDT and service planning, the RN plays a vital role in clarifying clinical needs and disease management.

1. Source of Information

Document the source of information in the appropriate space. If someone other than the member is the source of information, document name and relation to member. It is possible that information will come from both the member and a reliable source.

2. Health Conditions

This section provides detailed information about a member's current conditions and health history. For each condition listed you will ask:

If the member currently has or has ever had the condition, "Has a doctor told you that you have any of the following health problems or symptoms of health problems"?

If the condition interferes with living, and if so, how it interferes,

If the condition is under treatment, and

Number of years member has had the condition.

Information about the various health conditions is available on Internet Web sites such as: http:// www.WebMD.com , http://www.nlm.nih.gov/medlineplus and http://www.Medscape.com

Reviewed Column

The assessor/case manager checks each condition as it is explored with the member.

Health Conditions Column

For each condition listed, ask the member

"Has a doctor ever told you that you *currently have or have ever had* _____*?"*

After reviewing all the conditions, ask the member,

"*Do you have any health problems that I haven't asked you about*?"

Present Column

If the member answers "yes" to a health condition and the condition is current, place a check mark in the Present column, and document type.

If the member answers "no", then move on to the next condition.

Interferes With Living Column

For each condition identified, past or present, ask:

"Does this condition interfere with your ability to carry out everyday activities like bathing, getting dressed, moving around or preparing a meal?"

If the member answers "yes", then check the Interferes with Living Column. For each condition identified as interferes with living, an entry must be made as to *' how'* it interferes. Ask the member: "How does it interfere?" The comment may be the member's response.

Service Plan implications: A "yes" response should be explored and addressed in the service plan. You should consult with registered nurses on the team as an integral part of this process. Understanding how a disease process interferes with a person's daily living will help identify needs. Is the member short of breath from congestive heart failure? Does this mean he/she needs assistance with laundry? Does the member experience hand tremors and shaking from Parkinson's disease, and therefore needs meal preparation? As an assessor/case manager, you will want to be thorough in your evaluation of anything that interferes with living. Member needs are identified in this way. Services to address the needs are included in the service plan.

Condition Is Not Under Treatment Column

For each current condition, ask the member:

"Are you receiving treatment from a doctor or other health professional for (health condition)?"

If the member answers "no", then place a check mark in the Is Not Under Treatment Column. Conditions not under treatment have potential implications for service planning. Assessors will want to probe for more information and assure that these conditions are discussed so the nurse or other health professionals can use this information in the IDT.

Emphasize the intent of this column is to identify present (not past) conditions that are not being treated and to find out why.

Number of Years Had Condition Column

For present conditions, ask the member: "How long have you had (health condition)?"

Record the response.

For past conditions, ask the member: "How long ago did you have (health condition)?" or "What year did you have (health condition)?"

Record 'HX' (history), indicating this was a past condition, followed by the member's response.

Do not assume this question is non-applicable due to the member's age.

Repeat the steps outlined for each health condition listed on the UCAT.

If the member indicates that he/she does have additional health problems, enter these in the space provided by "**Other**" near the end of the Health Conditions column.

The final question under Health conditions relates to the use of **Substance abuse.** The intent of this question is to determine whether the use of substances interfere with the member's health and medication use, daily living activities, relationships, emotional or mental health. Explanations or definitions of "substance" may be needed depending on the age and experience of the member. As with all assessment questions, nonjudgmental and professional interviewing skills are essential.

Notes: The Notes area allows you to record details about a condition, how it is interfering with living, how it is being treated and how effective the treatment is or if it is not being treated, then why. The Notes area can also be used to document the use of home remedies, cultural beliefs and practices or any pertinent health information that will assist with service planning.

Level of care and Service Plan implications: Detailed information about health conditions and how they interfere with living is used in determination of level of care. Some persons with progressive degenerative disease processes, although not currently nursing home level of care may still be eligible for services using expanded eligibility criteria. Thorough documentation allows for the most appropriate level of care determination by OKDHS and OHCA. Some programs define the targeted group of people it can serve. Individuals with mental retardation or cognitive impairments may be ineligible for some programs. Additionally, individuals with mental illness as the primary need for service may be ineligible for some programs. Service plans need to reflect accommodation of health conditions to provide for health and safety of the member. The case manager must include service strategies to mitigate high risk indicators. A history of falls needs to have fall prevention addressed in the goals. Evidence of wounds indicates a need for wound management including a possible need for skilled care. A member requiring a ventilator must have maintenance and management addressed in the goals. Goals must address how the member is supervised and supported throughout the 24 hour period when the need is documented within the UCAT. The appendix provides example strategies to address high risks, such as frailty, for the case manager to incorporate in to the plan.

Service Plan implications, cont'd: Advanced Personal Care services and goals may be required when the member needs care with a tracheostomy, gastrostomy, colostomy, external catheters, need for a bowel program, need for application of medicated lotions or ointments, and dry, non-sterile dressings to unbroken skin, use of lift for transfers, manual assist with oral medications, passive range of motion exercises, etc.. For the case manager to avoid delay in service authorization, goals must be completed to address unmet needs related to memory problems, fall history, wounds, need for medication management, equipment use, etc..

3—6 Drug, Alcohol and Tobacco Use

This section of the Health Assessment asks the member about drug, alcohol and tobacco use. These substances may pose health or safety risks that need to be addressed in service planning.

3. Drug Usage

Ask the member: "Do you use any recreational substances, for example, marijuana, LSD, crack cocaine, barbiturates, designer drugs, or inhalants? "
Be sure to document use, frequency, past use and when quit as applicable.

4. Alcohol Consumption

Ask the member:
"Do you drink any alcoholic beverages including beer and wine?"

If the member drinks alcohol, ask further probing questions to document use, frequency, past use and when quit as applicable.

"How much do you drink, including beer, wine, and other alcoholic beverages?"

Example: Three drinks, two days a week. Explain to the member that 4 ounces of wine, 1 ounce of whiskey, and 12 ounces of beer are equal in alcohol content.

5. Tobacco usage

Ask the member:

"Do you smoke, chew, or dip tobacco?"

Check "yes" or "no". If the member answers yes, inquire as to how much.
Smoke: "How many cigarettes per day/packs per week do you usually smoke?"

Dip tobacco: "How long does a can last? How frequently do you dip throughout the day?"

(Dips are of different sizes and number of cans used may give a clearer indication of amount of use.)

Chew tobacco: "How many pouches per week do you use? How long does a pouch last?"

Ask the number of years of use of each product mentioned. If they indicate they smoked, dipped, or chewed tobacco in the past but no longer do, specify when they quit.

6. Assessor/Case Manager's Assessment of Substance, Alcohol, and Tobacco Use

This item is **answered by the assessor/case manager only**. Professional judgment and observation skills are used to assess whether or not a member's use of these substances is cause for concern.

After answering the question,

"Are you concerned about a member's alcohol use, substance abuse and/or careless smoking?", the assessor/case manager provides objective documentation to justify the answer.

For example, an answer of "no" might be justified by, "Ms. Doe does not smoke, drink alcohol, or use recreational substances". An answer of "yes" might be justified by, "numerous cigarette burns were observed on the sofa and on the carpet near the bed" or "Ms. Williams smokes while her oxygen is on".

Comments/Conditions Unique to Member

This space is provided for the assessor/case manager to record a detailed but concise summary of items 2—6. It is not necessary to repeat all the information gathered in these sections. The focus should be on issues that currently affect the member's health and welfare and will need to be addressed at the IDT. Written statements should be professional at all times and must be based on observed facts and avoid subjective comments.

Service Plan Implications: When substance use poses a health and safety risk, you will want to address this with the member, and in the service plan. Is a referral to an alcohol treatment program recommended? Is the member interested in a smoking cessation program? Consider, again, the member's MSQ. Was it over 12? Did you observe careless smoking during the interview? Interventions for substance use are a sensitive matter. Be aware that some cultural or religious practices may involve use of some of these substances. Be sure to explore the subject with the member respectfully and professionally. Do not use labels like "alcoholic" or "drug abuser". Instead, simply report the usage and any interest in treatment options the member expresses. Understand that use of substances is an individual's choice and that treatment of any kind is a person's choice as well. This can be further explored at the IDT meeting and addressed with member-directed goals and action steps in the service plan.

7-10 Medication Use

Thorough and ongoing assessment of medication management is a critical case management task. It is estimated that at least 1 out of every 5 hospital admissions is related to problems with medications. Cost, poly-pharmacy, complex regimens, multiple physicians, prescribing errors, and administration errors present special challenges that frequently threaten a member's health and welfare. Assessor/case managers will want to work closely with the RN to identify and immediately address any medication concerns. It can also be helpful to obtain information from the member's pharmacist, physician, and/or other medical records. **Be sure to document if the member has Medicare Part D as a payor source.** Web sites such as http://www.WebMD.com and http://www.fda.gov/consumer provide excellent information related to medications, avoiding drug interactions, over the counter medications, medication safety , etc..

7. Medication List

Ask the member: "Are you taking any medications?"

If "no", then record that the member does not take medications and proceed to #8.

If "yes", then ask to see all medication containers and record the prescriptions, over-the-counter, herbal and other alternative medications. Remember to ask about medications that may be stored in special places, like the refrigerator or a shoe box. When listing medications, it is helpful to group them by category: prescription, over-the-counter, herbal, etc.

Name

Fill in the Name column by listing all medications.
Example: Lopressor, Lanoxin, Cognex, etc.

Dosage

Fill in the Dosage Column indicated the correct dose prescribed.
Example: 200 mg.

Frequency

Complete the Frequency Column by listing the number of times a day that the medication is prescribed. The frequency can be written in English or medical symbols may be used.

ELDERs format includes a section HERE to include the Prescription #

Physician

Complete the Physician Column by indicating the name of the physician prescribing the medication.
Example: Terrence Johnson, M.D.

Date Filled

Enter the date the prescription was filled in the Date Column. It may be helpful to make notes in the margins regarding purpose of medications. The member may or may not know why a medication is taken, but you can identify medications that may be taken for no obvious reason, or medications given for a condition the member failed to mention in #2.

Example: If the member is taking medication for hypertension and the medication bottle is empty, contact the physician. Abrupt discontinuation can worsen many health conditions. Review section 2 to see whether hypertension or other cardiac problems are indicated.

Example: The medication bottle instructs the member to take a medication four times a day for 10 days and you would know that 40 pills were originally in the bottle. If 10 days have passed, and 25 pills are left in the bottle, you would then know that the member is not taking the medication as prescribed.

8. Pharmacy Used by member

Ask the member:

"What is the name, address, and phone number of the pharmacy that you use most?" If

the member knows the name, you can look up the address and phone number in the telephone book. This information will be valuable in helping you determine whether the member is taking his/her medication properly. If the member does not know, check the bottle or contact a reliable source.

If there is more than one pharmacy used, include that information in the comment or additional information section as available.

9. Medication Schedule

Ask the member:

"How do you remember to take your medications?"

Do not read the list. Wait for the member's answer. Use the list as a prompt only.

If the member does not know, ask the member:

"Does your spouse give them to you?"

"Do you use a calendar or log?"

"Do you use a pill minder? Who fills the pill minder?"

Place a check mark on the Other column if the method described by the member is not on the list and specify the method the member indicated.

10. Assessor Concerns

These questions are answered by the assessor/case manager. The intent of these questions is to identify possible risk indicators when there is a question concerning medication adherence. If an assessor/case manager is uncertain, he/she can contact the RN, the member's physician, and/or pharmacist.

Any item checked "yes" requires explanation in the provided comment space. These issues require resolution in order for the member to remain safely at home and must be addressed by the case manager in the service plan. In consultation with the RN, assessor/case managers can explore informal supports such as family members and formal options such as Medicare Home Health and AD*vantage* skilled nursing visits.

If there are no medication concerns, indicate so in the comment box in order to demonstrate that the items were reviewed.

Place a check mark in the appropriate column based upon your judgment.

Example: Number of pills in bottle does not correspond with available information on date prescription was filled.

Example: You notice that the member is lethargic and that he/she is taking Valium. You should document specific observations, i.e. that the member appears lethargic. Recommend medication evaluation. You should check "affected by drug side effects" and "not getting med needs evaluated".

Example: You notice that the member has been prescribed medication by two different physicians. One doctor prescribed Lasix (trade name) and another doctor prescribed Furosemide (generic name). You should check "taking prescriptions from too many physicians". Documentation would indicate "taking both Lasix (Dr. Johnson) and Furosemide (Dr. Stamps).

In the Comments/Service Implications box, record information on any medication usage that may need monitoring.

Example: Is the member over/under using medication?

Example: Is the member not taking medication at all?

Example: Is the member experiencing adverse side effects?

Example: Is the member not taking medications on time or not taking the proper number of medication?

Example: Is the member going without medication due to cost?

Service Plan implications: All concerns noted in the comments section must be addressed in the plan of care for the member. Additionally, assessing medication use provides a good opportunity to explore cultural influences and preferences. How does the person and the family feel about taking prescription medicines? Are they substituting or supplementing with home remedies or culturally based practices? How important is it to the member to continue with those remedies or practices? Are those remedies and practices helping or hindering the member's health? Does the member need information to make an informed decision? How will the team support the member's right to choose his/her treatments? The service plan should reflect the member preferences, choices, and his/her informed decisions.

11-12 Medical Utilization

The Medical Utilization section of the Health Assessment assesses the member's use of medical services over the **past six months** as well as the member's previous experiences in nursing facilities, residential care homes, or similar places.

11. Medical Utilization

Ask the member:

"In the past six months, have you seen a doctor, physician's assistant, nurse practitioner, eye doctor, foot doctor, dentist, or hearing examiner, been admitted to a hospital or gone to any emergency room?"

If the answer is "yes", place a check mark in the box next to Yes and complete the remainder of the item.

Name of facility or physician: If the answer is "yes" enter the name of the physician, hospital, or emergency room, such as Dr. Johns or Mesa Hospital. Enter the type of facility here also such as ER visit, hospital, etc..

Date: Enter the admission date or the date the physician was seen. If the member does not know, ask for an approximation.

How Long: Enter the member's discharge date if applicable. You may also indicate the duration of the visit if this is the response given.

Reason for Visit/Admission: Enter the reason for the admission or office visit.

If the answer is "no" place a check mark in the box next to No and go to #12.

Service Plan implications: Supporting information presented in this section related to transportation hours for those program services that allow for this will prevent potential delays in service authorization.

Recent hospitalizations, emergency calls, and frequent physicians visits may be an indicator of unstable or fragile health. Make a mental note of this possibility and be aware of it as you evaluate and monitor needs. It could mean that you will want to monitor this member more frequently. If needs are changing frequently, the case manager will want to amend the service plan to reflect current needs and services.

Conversely, if the member has not seen a physician in more than 6 months, this may indicate that he/she doesn't have a physician. Do you need to assist the member in locating a physician? Do you need to encourage him/her to make an appointment? Has he/ she not seen a doctor because transportation is unavailable? Do you need to help him/ her arrange transportation? Are there cultural barriers preventing him/her from seeing a doctor, such as, does the doctor need to be of the same sex or ethnic background? Each of these considerations should be probed and addressed in the service plan.

12. Nursing Home Residence

This is a critical question.

For a response of "yes", indicate on the form and complete the remainder of the item.

Admission Date: Enter the date the member was admitted to the facility.
Discharge Date: Enter the discharge date, if applicable.
Name of Facility: Enter the name of the facility and or facility ID# if known.
Reason for Admission: Enter the reason for the member's admission such as respite, recovery, etc..

For a response of "no", indicate on the form, and go to the next item.

If the answer is "don't know", try to find a more reliable source. If the member has been a resident, there is a good possibility that a previous assessment was performed.

Explain a "similar place," such as a Group Home or Residential Care Facility.

Ask the member:

"Have you ever been a resident of a nursing home, residential care facility, or similar kind of place?"

Level of care and Service Plan implications: Statistics show that persons who have previously lived in a nursing facility are at higher risk for re-entry. Potential for successful community living is also at risk. This is due to a variety of factors, however, usually results from a lack of sufficient resources, formal and informal. When you have identified a member has previously resided in a nursing facility, it is critical that you explore the reasons for that nursing facility placement. As a Case Manager you are responsible for putting together a plan that coordinates sufficient formal and informal supports. Understanding the individual's circumstances for entering the nursing home will be vital to the development of a successful community living plan. The plan should include monitoring at a level necessary to assure the health and welfare of that individual. When nursing home placement is necessary for health and safety of the member, the case manager assists the member in accessing institutional care and takes a very active role in the transition to and from the nursing home stay. Some programs provide facility based respite and transitional case management as a service. The case manager must be aware of these service options to assist a member's moves with as little interruption in care as possible. Nursing Home stays require medical and financial eligibility. The case manager's monitoring of the member's situation can facilitate any needed eligibility determinations by prompt communication with OKDHS.

13. Special Equipment/Assistive Devices

Introduction

This section assesses any special equipment or assistive devices needed or used by a member. For each of the items listed, the assessor/case manager determines if the member:

Has and uses **Has but does not use** **Needs, but doesn't have**

During this assessment, an assessor/case manager may also identify the need for evaluations by other health professionals such as a Physical or Occupational Therapist. A Comment/Service Plan box is provided to document the member's needs or other information that may have service plan implications.

Additionally, assessor/case managers need to consider available payor sources, remembering a Waiver Program is the payor of last resort. Durable Medical Equipment Supply companies (DMEs) who are certified by the Waiver Program can help you determine the customary payor source as well as the item's billing code and cost.

Use the list of equipment to locate each device or aid. For each device in this list, ask the member:

"Do you have and use (the device or aid)?"

If the response is yes, check the appropriate box in the Has and uses or doesn't use column.

Needs and does not have. If it appears that the member needs and does not have a certain item, identify that item and any other not checked.
Ask the member: "Do you need and not have this item?"

Example: If dentures are not checked, ask the member: "Do you need dentures?"

Other. Ask the member: "Do you need any equipment that I haven't asked you about?"
If the response is "yes", enter the name of the equipment in the space after "Other".

Comments/Service Plan Implications

For each item checked "yes", record the current provider and list of supplies used. This space is also used to record unmet needs, identify service plan implications, and to make recommendations.

Service Plan implications: All equipment/assistive devices needs must be included in service planning. The service plan action steps will need to address who will provide the item (i.e. DME, family member, Indian Health services, etc), who will install the equipment/device, who will maintain the item, and who will provide training on its safe use. Once in place assessor/case managers monitor and document its use and effectiveness through observation and reports from the member and caregivers. When applicable, the assessor/case manager will also want to request reports from any other health professional (such as PT, OT, Counselor, etc.) involved. When recommending PERS, keep In mind a land line must be maintained in the home.

14 Medical Treatments and Therapies

Introduction

Information concerning a member's medical treatments and therapies is recorded here. Each item on the list is assessed and if the member is receiving a service, the frequency is noted and a brief explanation, which includes the current provider, is given in the comment box. The comment box is also used to identify unmet needs and make recommendations for services. All treatment and therapy needs will need to be discussed at the IDT and addressed in the service goals and service plan. Assessor/case managers will want to include the nurse and other clinical professionals as needed. As with Special Equipment/Assistive Devices, the payor source is also a consideration; and a certified AD*vantage* DME company can be consulted.

Ask the member: "Do you receive any of the following medical treatments or therapies?"

Name each item and check the "yes" or "no" accordingly. Include type here.

Frequency

For each item checked "yes", record how often the member receives the treatment or therapy .

Comments/Service Plan Implications

For each item checked "yes", record the current provider and list of supplies used. This space is also used to record unmet needs, identify service plan implications, and to make recommendations.

Service Plan implications: Be sure to include treatments and therapies in the service plan, even when they are not provided by the waivers. Include who is providing the treatment/therapy, and the frequency. As an assessor/case manager, it is necessary that you communicate with treatment/ therapy providers regarding the need for continued treatment/therapy, as well as the providers' plan for continuing to deliver the service. You are responsible for coordinating the care and ensuring that it is delivered appropriately. Consider if the lack of a treatment or therapy interferes with living. Plans for mak ing treatment referrals and monitoring them are included in the service plan. Specialized medical equipment and supplies not paid for from other sources may be available through the waiver. Only those items that enable the member to increase ability to perform activities of daily living, or to perceive, control, or communicate with his/her environment and in order to prevent institutionalization are considered for approval. Included are items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of these items, and durable and non-durable medical equipment not available through other sources. Some items, such as Personal Emergency Response System (PERS) require specific service criteria and strategies within the plan of care to be approved. The case manger is responsible for monitoring supplies to ensure only the actual needed amounts are written into the plan. The case manager is responsible to provide advanced supportive/restorative or skilled assistance when some equipment and/or treatments are used routinely in the home. Any equipment and/or supply item which is not of direct medi- cal or remedial benefit to the waiver member is excluded from consideration.

15. Diagnosis Code

This item is completed by the assessor. If the information gathered in health conditions is inconclusive concerning a primary or secondary diagnosis, assessors can check medical records, if available, or call the Member's physician. The physician may also provide the appropriate ICD-9 codes. Avoid using V or E codes as these can cause billing problems.

Record the primary and secondary diagnosis names.

Record the Diagnosis Code (ICD-10 code). There are free Internet sites that provide updated codes. Example: www.icd10data.com

Level of care and Service Plan implications: It is a good idea to understand diagnosis and disease processes that are associated with them in the thorough development of a service plan. For example, a person with Type I Diabetes is insulin dependent. The service plan implications of this Include monitoring the person's blood sugar. Who is responsible for this? Does the member monitor it independently? Or is it a family member? These are just a few of the questions that should be asked and addressed in the service plan. Always remember to consult with a Registered Nurse regarding diagnosis and disease processes associated with it. RNs are an equal and integral part of the ser- vice planning process and will establish a disease management plan for the member. As an assessor/case manager, you need the same basic understanding of how to manage a disease process as the member needs, so you can monitor the disease management outcomes. Indicate if mental illness is the primary diagnosis. However, realize some pro grams cannot serve members whose need for services is primarily related to mental illness.

16-22 Nutrition

Introduction

This section of the UCAT guides the assessor through a comprehensive evaluation of a Member's appetite, weight loss or gain, problems with eating, special dietary require- ments, and eating habits. Identifying nutritional needs is a critical task because nutri- tional health is a core issue that can directly affect a person's ability to remain at home. Malnutrition is a leading cause of nursing facility placements. Moreover, obesity is the underlying cause of many chronic and debilitating illnesses and successful disease management strategies of both acute and chronic health conditions, often depending upon specialized dietary requirements. Learning about diet and/or lifestyle behaviors can also provide insight into a Member's preferences, cultural practices, motivation, and attitudes about his/her health. **NOTE**: If the ELDERs format is being used, scores are automatically added in this section.

16. Appetite

This is a subjective question. The answer indicates the member's own perception of his /her own appetite. Check "good", " fair", or "poor" according to the member's response. Enter the corresponding number on the line next to Score.

Example: If the Member's answer is "fair", the score is '2'.

17. Current Weight and Height

If the member's medical records are available, obtain this information from the admission notes. If no medical records are available, enter the weight and height that the member or caregiver provides you.

18. Weight Gain/Loss

The intent of the question is to identify significant *unintentional* weight loss or gain. Significant is defined as unintentional weight changes of 10% or more which could indicate a health problem. Ask the member:

"Have you gained or lost weight in the last six months?"

If the answer is "no", then check "no" and proceed to the next question.

If the answer is "yes", then ask:

"How much weight have you gained/lost?"

If the member has either lost or gained more than 10% of his/her weight in the last six months, then ask: **"Was this intentional?"**

If the change in weight was 10% or more **AND** it was unintentional, then document "yes" and enter the number of pounds lost or gained in the corresponding space. The score is '4' if 'yes' is indicated for this item. Be sure to document any contact with the physician regarding the weight change and the result of that contact.

Service Plan implications: When a member has gained or lost a significant amount of weight, it should be evaluated. Is the member losing weight because he/she is unable to prepare meals? Or is it possibly due to tooth and mouth problems? You should explore the reasons and address them in the service plan. Do you need to include meal preparation services? Home delivered meals? Nutritional supplements? Perhaps arranging for dental services or services of a dietician is appropriate. It might be appropriate to include skilled nursing by a Medicare/Medicaid Home Health Agency to monitor further weight loss or gain. Oral nutritional supplements authorized by some programs require specific service criteria and strategies within the plan of care.

19. Problems with Eating

Using the list on the form, ask the member whether he/she has any problems that make it difficult to eat.

Examples:
"Do you have problems with your teeth or mouth that make it difficult to chew meat?"

"Do you have problems with swallowing?"

"Are you allergic to certain foods?"

If the response to the food allergy question is "yes", try to distinguish between real food allergies and personal dislikes.

Add scores of No (0) or Yes (4) and place the total in the box as per the member's responses. Justify any 'yes' answers that indicate a problem with eating.

Comment Box/Service Plan Implications

This comment box relates to items #16-#19. If a member has had significant weight changes or problems with eating, then describe the causes and add recommendations for referrals, if appropriate. For example, would the member benefit from dental care? A swallow study? Need to see a specialist to address any underlying condition? Interested in a weight loss program? If a member has problems with their teeth, but it does not make it difficult for them to eat you may want to comment about this here to justify why a score of 0 was given above.

20. Special Diet

Ask the member:

"Are you on a special diet that the doctor or another health professional told you to follow??"

If the answer is "no", then check the "no" box and place a zero (0) on the line next to Score.

If the answer is "yes", then ask

"Are you following the diet?"

Check the number of diets and place the corresponding score on the appropriate line.
Ask to see any written diet plans the member has and probe to discover how the plan is working for the member, problems he/she may be having, and education needs.

21. Prescribed Medication

The Assessor answers this question based on information gathered in previous sections. If the member takes three or more prescriptions or over-the-counter medications, then check "yes" and enter the score (2) on the corresponding line.

If the member takes less than three prescriptions or over-the-counter medications, then check "no", and enter the score zero (0) on the corresponding line.

Service Plan implications: Poor nutrition and/or drug-nutrient interactions can also alter how a drug is absorbed by the body, increasing the risk for adverse reaction. Assessor/case managers will want to consult the nurse with these concerns. A member's pharmacist and/or physician may also need to be contacted. If it is concluded the member is at risk, these issues will need to be addressed and service plan implications may include increased monitoring, skilled nursing visits, physician appointments, and a disease management plan. Service planning may also need to address appetite problems related to medications.

22 Intake on a typical day

This section assesses a member's intake over the course of a typical day.

Typical Diet

Briefly describe what the member usually eats and drinks during a typical day, including weekends. Enter one mark for each serving of a food group the member eats and drinks in a typical day. **Do NOT add totals for this section into Nutrition Total Score**.

To assist in that process, lists of food groupings plus fluids are listed at the left side of the UCAT.

As the member (or best source of information) describes what he/she had to eat in a typical day, place a tally mark in the corresponding line on the UCAT matching food amount, type, and time of day.

If the member has difficulty describing a daily menu, ask: "What did you have for lunch?" Record the information using tally marks. "Did you have breakfast or a snack earlier today?" "Do you recall what you had for supper/dinner last night?" "Any snacks?" Information may be given out of order. Place tally marks as foods eaten are reported.

Specify any religious or self-imposed diets practiced (avoidance of certain foods, etc.).

Refer to the Appendix for calorie requirements and serving information. Also, refer to Internet Web sites such as www.health.gov/dietaryguidelines.

Total Nutrition Score

The following questions are assigned a numerical score so that the nutritional risk can be determined. Numerical values for the questions are in parenthesis.

16. How is your appetite? **Good (0), Fair (2), Poor (6)**

18. Have you gained or lost a significant amount of weight in the last six months? **Yes (4), No (0)**

19. Do you have any problems that make it difficult to eat? **Yes (4), No (0)**

The three eating problems that are assigned a score value in this question are tooth or mouth problems, swallowing problems, and nausea/vomiting. The total possible score for this question is 12.

20. Are you on any special diets for medical reasons? Choose only one of the following: **None (0), 1 special diet (4), 2 or more special diets (6)**

21. Does member take 3 or more prescribed or over the counter drugs daily? **Yes (2), No (0)**

Make sure that the numbers in these boxes match the numerical values of the responses checked.

Add the numbers in these 5 boxes and record the total in the Nutrition Total Score Box.

Level of care and Service Plan implications: Poor nutrition impacts the level of care needs a member has and ultimately the service program required to meet those needs. Although state plan personal care is able to provide meal prepara- tion, a waiver program may be needed to supply nutritional supplements and other nutri- tional monitoring and interventions.

22. Subjective Evaluation of Health

Introduction-This question asks the member to evaluate his/her health. The question is important because research has shown that the way a person feels about their health can greatly impact health outcomes. Like the MSQ, only the member should answer this question. In the event the member is unable to participate, is unresponsive, or has severe dementia, consult with a reliable source and use the information from this source to assign a score. Document why the member could not respond and who was consulted.

Ask the member:

"Overall, do you consider your health as excellent, good, fair, or poor?"

Check the box that corresponds to the member's answer.

Ask the member:

"What makes you feel that way?"

Record the exact response in quotations.

The score associated with the member's response in the Subjective Evaluation of Health Total Score: Excellent (0), Good (5), Fair (15), Poor (25).

A member may not be feeling well on the day of the assessment, meaning the condition may be temporary (e.g. head cold, didn't sleep well, etc.). Attempt to clarify how the member feels about his/her health most of the time.

23. Speaking and Communication

Document the choice that most clearly reflects the member's communication ability based on performance in the interview. Problems in this area need addressing in the care plan especially in reminders to caregivers, etc. Communication aides, speech therapy, etc. may be needed for the individual.

To determine HEALTH ASSESSMENT CLINICAL JUDGMENT
check one box in each column beginning with Health
Conditions and Stability. The overall
risk level and score is determined by the preponderance of checks.

OVERALL RISK LEVEL	SCORE	HEALTH CONDI-TIONS AND STABILITY	CONTROL OF NEEDS SYMP-TOMS	UNMET TREAT-	MEDICAL NURSING MENT/ OVER-SIGHT	RISK OF TIONAL HOME ADMIS-SION	FUNC- CAPACITY
Low	5	1 or more chronic, stable health condi-tions	Controlled or nearly controlled	May have an unmet need for service available only through Waiver or NF	Benefits from avail-able or usu-ally avail-able medical treatment or corrective measures	Not likely	Varies
Moderate	15	1 or more chronic, changing health condi-tions	Fragile or worsening	Has multiple unmet needs for services available only through Waiver or NF	Requires medical care/ oversight to bring under control or to maintain in a stable, controlled state	Likely to enter a NF if these needs are not met.	Varies
High	25	1 or more chronic health conditions	Rapidly deteriorat-ing, uncon-trolled, or not well controlled	Has multiple unmet needs for services available only through Waiver or NF	Requires a high fre-quency or intensity of medical care/ oversight to bring under control	Requires NF placement immediately if the needs cannot be met by other means	Functional capacity is so limited as to require full-time assis-tance or care performed daily by or under the su-pervision of professional personnel

Clearly document your clinical decision indicating ***why*** you chose the level you chose. Refer to specifics about this member that address health conditions and stability, control of symptoms, unmet needs, medical treatment/oversight and likelihood of nursing home admission in the future.

24.Health Assessment Clinical Judgment

The assessor/case manager assigns a Health Assessment risk score based on information collected from items #2-#15. The information is compared to established criteria and corresponding scores for low, moderate, and high risk. Once a risk level is determined, the assessor/case manager is required to document how a member meets the criteria for the risk level chosen. The risk level must be supported by the information obtained in the health assessment. Clearly document the clinical decision indicating with **specific personal in- formation related to the member's** health conditions and stability, control of symptoms, unmet needs, medical treatment and oversight, risk of nursing home admission and functional capacity as to ***why*** the risk level was chosen. Use the grid on the previous page as a guide by checking one box in each column that best identifies the member's current situation. The overall Health Assessment Clinical Judgment risk level and score is deter mined by the risk level with the preponderance of checks.

Level of care implications: Accurate and precise information indicating a Health Assessment Clinical Judgment is used by OKDHS and OHCA in determining level of care needs of members. It is vital this information is clear and agrees with the remaining documentation within the UCAT to assure the member is given services in the most appropriate service program.

Comment/Service Plan Implications-Summary

The summary section is typically completed last and away from the interview site to ensure deliverance of a holistic picture of the member and his/her circumstances. This space for documentation provides an opportunity for a professional summary of the health assessment of the member. For individuals wishing to remain in their own home, it should be a synthesis of the health of the individual and a summary of the **baseline services required to prevent premature institutionalization.** Assessors may wish to list member strengths and challenges as a method of addressing service plan implications. At reassessment, the professional summary should note any changes, improvements or deterioration in condition, new treatments, etc. This space is also used to summarize the information gathered in a completed UCAT. Key information from each domain is included, as well as a member's abilities, needs, goals, preferences, existing services, informal supports and all issues that would need to be addressed in the service plan. Concerns related to health and safety of the member is summarized in this area. Referrals to Adult Protective Services and follow-up is noted here. The need for 24 hour support should be clearly docu- mented in this area.

Service Plan implications: Personal goals are just about anything that motivates and may be achievable, i.e. go to church, volunteer, etc. In short, personal goals will be unique to the member. Personal goals need to be clearly defined/labeled and included in the plan of care. Include the member's realistic wants and desires; what he/she may have lost and wishes to regain in life and activities the member wants to participate in. While service provision is limited to addressing "needs", the assessor/case manager should explore with the member ways to meet personal goals using additional resources available.

Functional Assessment

Introduction

The purpose of the Functional Assessment is to determine the member's ability to perform their Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). This section also identifies assistance of other people in completing ADLs and IADLs and the adequacy of that assistance.

ADLs are activities that reflect the member's ability to perform tasks that are essential for self -care. ADLs include dressing, bathing, eating, transferring, mobility, stairs, toileting, bladder/bowel control and managing incontinence.

IADLs are activities that reflect the member's ability to perform household and other tasks needed to meet their needs within the community. IADLs include answering the telephone, making a telephone call, shopping/errands, transportation ability, preparing meals, laundry, light housekeeping, heavy chores, taking medications and managing money.

The additional (Physical) assistance or (Direct) supervision required to meet these needs may be a major factor in determining the type of services to be provided, appropriate program selection and referral sources. Remember, we are assessing what the member can complete on their own or have the potential to meet on their own if given the opportunity, what task they require some direct supervision or physical assistance or what they are completely unable to do on their own. We want to identify a member's strengths and abilities as well as unmet needs.

Physical Assistance: Hands on assistance is required from another person to complete the task.
Direct Supervision: Presence of another person is required to provide immediate assistance and/or direction for completing the task.

Functional Assessment

There are 22 items to be completed in this section.

1. Source of Information
2. Dressing
3. Grooming
4. Bathing
5. Eating
6. Transferring
7. Mobility
8. Stairs
9. Toileting
10. Bladder/Bowel Control
11. Wearing Incontinence Briefs/Appliances/Training Programs
12. Changing Incontinence Briefs/Appliances/Training Programs
13. Answering the Telephone
14. Making a Telephone Call
15. Shopping/Errands
16. Transportation Ability
17. Preparing Meals
18. Laundry
19. Light Housekeeping
20. Heavy Chores
21. Taking Medications
22. Handling Money

Tips for Assessing ADLs & IADLs

Give the member an overview of the functional assessment	As with all sections of the UCAT, it is helpful to give the member an overview of the functional assessment before starting the questions. Explain that you will be asking a group of questions about self-care, household, and community activities. Acknowledge that some of the questions, such as those concerning toileting or bowel and bladder control, may seem personal and embarrassing to answer. Offer reassurance that the answers to these questions are important so that all concerns can be addressed in service planning within the appropriate program. If the questions are asked without embarrassment or hesitation, the member is more likely to feel comfortable.
Get an accurate description of the member's abilities	Each ADL and IADL actually involves multiple activities. Dressing, for instance, includes getting clothes out, putting them on, fastening them, and putting on shoes. It is often necessary to ask probing questions until you have an accurate description of the member's abilities. Being specific as to what parts of the task the member can and can't do helps in later determining time allocations.
Observe the member engaging in an ADL/ IADL	Whenever possible it is also helpful to observe the member. For example, during the health portion of the assessment, Assessor/case managers may have the opportunity to see a member getting out of a chair and walking to get his/her medications.
Assess strengths and limitations	Be sure to assess the Member's strengths as well as limitations. Case Managers note any part of an ADL or IADL a Member can do independently, and what part he/she needs assistance with. Any task a Member needs assistance with is addressed at the Team meeting. All ADLs and IADLs, including those a Member can do without assistance, will need to be accounted for in the Service Plan.
Use specific terms and recommendations when known	Include unit, frequency and duration of unmet needs. Remember service recommendations are not intended to take the place of regular care and general household maintenance tasks typi- cally shared or done for one another by spouses or other adults who live in the same house- hold. Service recommendations are not made for services that principally benefit the family unit. Services recommendations are adjusted when paid caregivers live in the household. When an informal system of family or significant others is available within the home, services are to supplement the system to support continued caregiving over extended periods.
Carefully use Assessor Overrides	If the Caregiver, or other informal support person disagrees with the Member's answer, choose the score that matches the member's response, but record the informal support person's com- ments in the comment box. If the Case Manager feels the member over or underestimates his/ her ability, an assessor override can be used. Any time an assessor override is used, the assessor/case manager notes the discrepancy and provides justification in the comment box. For example, if the member states he/she has no problems with toileting, but you notice soiled clothing, stained furniture and an odor of urine in the house, document objectively in the com- ment box. Confirm discrepancies that require an override, with another source, when possible.
Discover the member's cultural values and personal preferences	Assessing functional abilities also provides an opportunity to discover a Member's cultural values and preferences. How often Members bathe, how they define a clean house, who manages money, etc. can vary greatly from culture to culture and even person to person. Ask questions such as "How often do you like to bathe?" "What time of day?" "Does your culture or religious beliefs require you to wear certain clothing or fix your hair in a particular way?" Can your PCA be someone of the opposite sex?" "Do you want help cleaning this or are you more comfortable with these things around you?" "Are there certain items or areas, such as religious shrines, that should not be disturbed?" What times do you prefer to eat your meals?" "What are your favorite foods?" "Are there foods you don't or can't eat?" This type of information will be important in the development of an individualized and Member-directed service plan.

Definition of Answers

No assistance

Indicates the member is able to perform the activity without any assistance from another person. Assistance with equipment to perform the activity is a "no assistance" response. This receives 0 points. No assistance also means that the member can perform the activity without supervision or reminders.

Some assistance/supervision

Indicates that the member requires guidance or management including verbal prompts, reminders, or physical assistance from another person during part of the activity. This receives 2 points.

Can't do at all

Indicates that the member is completely unable to perform the activity without total physical assistance from another person(s). This receives 3 points.

Activities of Daily Living (ADLs)

Process

Activities of Daily Living

Areas of information: Nine columns are provided for each ADL

1. Name and definition of the activity
2. No assistance
3. Some assistance/supervision
4. Can't do at all
5. Comments (required for scores of 2 or 3) 6.

Name and Phone number of assistant(s)

7. Assist code/appropriate identifying source 8.

Frequency, hours, etc.

For each of the ADL and IADL activity items, the member is asked whether he/she needs assistance from another person to complete the task. The three possible answers are:

1. No assistance	Score = 0
2. Some assistance/supervision	Score = 2 3.
Can't do at all	Score = 3

Read the choices first and then ask the member to choose one.

Document supportive information in the comment section. If a member needs no assistance with a task there is no need to proceed with the other columns. Document how the member is meeting the task as necessary. If a member needs some assistance or can't do an activity at all, the assessor/case manager is required to complete the information in all areas provided for that task.

The assessor/case manager provides information for each activity in the following sections:

Comments: Remember to document strengths and needs here including what specific assistance is needed **and** why the assistance is needed. Indicate how the member manages when assistance is not available. Who assists when the assistant is not present? What happens on the weekend?

Name and phone number of assistant(s)

Document name and telephone numbers* of formal and informal supports.

*Phone numbers need only be entered once per page.

Assistant code/source

Identify the formal and informal supports using the assistant codes and/or appropriate identifying source provided.

Frequency, hours, etc

Indicate how long (hours) and often (daily, weekly, monthly, etc.) the member is receiving assistance from the support(s) listed.

Assistance needed

Identify the current assistance the member is receiving as:

"Adequate" ***"Needs to be increased"*** ***"Needs to be decreased"***

For the initial assessment, list specific assistance needed in addition to what is already in place. Be specific about the task needed as well as the needed frequency. Assistance needed applies only to a true need, not merely a desire.

For reassessment, indicate if present services are adequate or if they need to be increased or decreased.

For example: ***"Adequate" "Needs Increased to 3xwk" " Needs Decreased to 1xwk" "Caregiver is returning to work." "Now able to complete on own" "Health Deteriorating"***

Service Plan implications: *Remember any special circumstances (bathe in bed, lives alone and cannot get out of bed independently, etc.) must be speci-specified in the care plan to clearly indicate the special need and steps to safely meet the need.* When discussing personal care concerns, assessor/case managers often use creative problem solving skills to satisfy members' preferences and support their inde- pendence. Could a member wear pullover shirts or ones with Velcro fasters instead of buttons? Could they wear slip on shoes instead of ones with laces? Would a larger brush or better grip enable the member to fix her/his hair? Could a rubber place mat hold a plate well enough for a member to cut his/her food? These and similar questions can frequently lead to simple solutions a member might be willing and able to use.

Intent of Assessment:

The intent of these two sections (ADL and IADL) is to determine a member's functional ability. Sometimes a Caregiver may be assisting with ADLs or IADLs even when a member is capable of completing the tasks independently. Scoring should be based on what the member is able to do. Emphasize the parts of the task the member can complete on his/her own. A key phrase to keep in mind is, "Could the member do the task if given the opportunity?

Not every assessor or assessor/case manager will agree with the guidelines that have been set in this UCAT Manual. However, for consistency and uniformity, the guidelines must be followed by all assessor/case managers.

1. Source of Information

Enter the source of information, other than the member, in the appropriate space. Remember, if the MSQ was 12 or greater, it is recommended you have an additional source of information.

Also, make sure the member agrees to having others present during the assessment. The member may not be comfortable answering personal questions in front of others.

2. Dressing

Tell the member: "***This includes getting out your clothes, putting them on, fastening them and putting on shoes. Would you say you "need no assistance" "some assistance/supervision" or " Can't do at all" "***

Read the level of assistance choices (and definitions as necessary) before obtaining the member's answer. Place the score into the appropriate column corresponding to the member's response. If the member indicates he/she needs no assistance, document how he/she is meeting the task. If the member indicates he/she needs some assistance/ supervision or can't do the activity at all, complete all remaining areas assigned to that task.

Comments: Remember to document strengths and needs, including unmet needs, indicating the specific assistance needed **and** why the assistance is needed. Indicate who assists and how the member manages when formal assistance is not available. What happens on the weekend?
For example:
"Can choose and put on dress, but arthritis in fingers prevents her from being able to work buttons or tie her shoes." "Frequent pain and stiffness to fingers"

Name and phone number of assistant(s)
Document name and telephone numbers* of formal and informal supports.
*Phone numbers need only be entered once per page.

Assistant code/source
Identify the formal and informal supports using the assistant codes and/or appropriate identifying source provided.

Frequency, hours, etc
Indicate how long (hours) and often (daily, weekly, monthly, etc.) the member is receiving assistance from the support(s) listed.

For example: ***"7xweek, 3xweek, every day (QD), 1hr per week, 1xmonth, etc."***

Assistance needed
Identify the current assistance the member is receiving as:
"Adequate" "Needs to be increased" "Needs to be decreased"

For the initial assessment, list specific assistance needed in addition to what is already in place. Be specific about the task needed as well as the needed frequency. Assistance needed applies only to a true need, not merely a desire. For reassessment, indicate if present services are adequate or if they need to be increased or decreased.

For example: ***"Adequate" "Needs Increased to 3xwk" " Needs Decreased to 1xwk" "Caregiver is returning to work." "Now able to complete on own" "Health Deteriorating"***

Service Plan implications: Remember any special circumstances (no mobility in left arm and left leg, etc.) must be specified in the care plan to clearly indicate the special need and steps to safely meet the need.

3. Grooming

Tell the member: "***This includes combing hair, washing face, shaving and brushing teeth. Would you say you "need no assistance" "some assistance/supervision" or " Can't do at all"***"

Read the level of assistance choices (and definitions as necessary) before obtaining the member's answer. Place the score into the appropriate column corresponding to the member's response. If the member indicates he/she needs no assistance, document how he/she is meeting the task. If the member indicates he/she needs some assistance/ supervision or can't do the activity at all, complete all remaining areas assigned to that task.

Comments: Remember to document strengths and needs, including unmet needs, indicating the specific assistance needed **and** why the assistance is needed. Indicate who assists and how the member manages when formal assistance is not available. What happens on the weekend?

For example: ***"Can wash face and brush teeth, but needs assistance with combing hair due to limited range of motion in shoulders." "Needs assist putting toothpaste on toothbrush related to paralysis of L. hand"***

Name and phone number of assistant(s)

Document name and telephone numbers* of formal and informal supports.

*Phone numbers need only be entered once per page.

Assistant code/source

Identify the formal and informal supports using the assistant codes and/or appropriate identifying source provided.

Frequency, hours, etc

Indicate how long (hours) and often (daily, weekly, monthly, etc.) the member is receiving assistance from the support(s) listed.

For example: ***"7xweek, 3xweek, every day (QD), 1hr per week, 1xmonth, etc."***

Assistance needed

Identify the current assistance the member is receiving as:

"Adequate" "Needs to be increased" "Needs to be decreased"

For the initial assessment, list specific assistance needed in addition to what is already in place. Be specific about the task needed as well as the needed frequency. Assistance needed applies only to a true need, not merely a desire.

For reassessment, indicate if present services are adequate or if they need to be increased or decreased. For example: ***"Adequate" "Needs Increased to 3xwk" " Needs Decreased to 1xwk" "Caregiver is returning to work." "Now able to complete on own" "Health Deteriorating"***

Service Plan implications: *Remember any special circumstances (cannot lift arm above shoulder, etc.) must be specified in the care plan to clearly indicate the special need and steps to safely meet the need.*

4. Bathing

Tell the member: ***This includes running the water, taking the bath or shower and washing all parts of the body, including the hair.***

NOTE: Getting into and out of tub/shower is addressed under the Transferring task. For purposes of this document, Do not include the transfer in the scoring of Bathing. ***Would you say you "need no assistance" "some assistance/supervision" or " Can't do at all"***

Read the level of assistance choices (and definitions as necessary) before obtaining the member's answer. Place the score into the appropriate column corresponding to the member's response. If the member indicates he/she needs no assistance, document how he/she is meeting the task. If the member indicates he/she needs some assistance/ supervision or can't do the activity at all, complete all remaining areas assigned to that task.

Comments: Remember to document strengths and needs, including unmet needs, indicating the specific assistance needed **and** why the assistance is needed. Indicate who assists and how the member manages when formal assistance is not available. What happens on the weekend? Additionally, information on how the member is bathed may be beneficial if bathing takes longer than ordinarily expected. For example: ***"Bath process includes 4 transfers with a Hoyer lift". "Can wash all parts of body but cannot lift arms to wash hair" "Can wash upper body but cannot bend over to wash lower legs and feet" "Can participate but requires reminders to wash body and put soap on wash cloth" "unable to do, requires complete bed bath/assist" "Tub/shower is not large enough to accommo- date member's size. Member is bathed in wheelchair in the middle of the bathroom using a hand held shower wand. PCA must then mop and dry the entire bathroom."***

Name and phone number of assistant(s)

Document name and telephone numbers* of formal and informal supports.

*Phone numbers need only be entered once per page.

Assistant code/source

Identify the formal and informal supports using the assistant codes and/or appropriate identifying source provided.

Frequency, hours, etc

Indicate how long (hours) and often (daily, weekly, monthly, etc.) the member is receiving assistance from the support(s) listed.

For example:***"7xweek, 3xweek, every day (QD), 1hr per week, 1xmonth, etc."***

Assistance needed

Identify the current assistance the member is receiving as:

"Adequate" "Needs to be increased" "Needs to be decreased"

For the initial assessment, list specific assistance needed in addition to what is already in place. Be specific about the task needed as well as the needed frequency. Assistance needed applies only to a true need, not merely a desire. For reassessment, indicate if present services are adequate or if they need to be increased or decreased. For example: ***"Adequate" "Needs Increased to 3xwk" " Needs Decreased to 1xwk" "Caregiver is returning to work." "Now able to complete on own" "Health Deteriorating"***

Service Plan implications: *Remember any special circumstances (bathe in bed, weight challenges, etc.) must be specified in the care plan to clearly indicate the special need and steps to safely meet the need.*

5. Eating

Tell the member, "***This includes eating, drinking from a cup and cutting up foods."***
Would you say you "need no assistance" "some assistance/supervision" or " Can't do at all"

Note: For purposes of this document, eating addresses the *physical ability* to feed oneself. The presence of feeding tubes and nutritional challenges are addressed under Health Assessment and Nutrition and are not scored in this section.

Read the level of assistance choices (and definitions as necessary) before obtaining the member's answer. Place the score into the appropriate column corresponding to the member's response. If the member indicates he/she needs no assistance, document how he/she is meeting the task. If the member indicates he/she needs some assistance/ supervision or can't do the activity at all, complete all remaining areas assigned to that task.

Comments: Remember to document strengths and needs, including unmet needs, indicating the specific assistance needed **and** why the assistance is needed. Indicate who assists and how the member manages when formal assistance is not available. What happens on the weekend? Address time issues when more than expected time is required for the task. For example: ***"Needs reminders to eat or drink due to effects of Alzheimer's disease." "Unable to cut up foods due to fracture to arm but can eat and drink on own." "Has feeding tube but physically able to eat, drink and cut up food" "Member must be fed slowly due to choking hazard"***

Name and phone number of assistant(s)

Document name and telephone numbers* of formal and informal supports.

*Phone numbers need only be entered once per page.

Assistant code/source

Identify the formal and informal supports using the assistant codes and/or appropriate identifying source provided.

Frequency, hours, etc

Indicate how long (hours) and often (daily, weekly, monthly, etc.) the member is receiving assistance from the support(s) listed.

For example: ***"7xweek, 3xweek, every day (QD), 1hr per week, 1xmonth, etc."***

Assistance needed

Identify the current assistance the member is receiving as:

"Adequate" "Needs to be increased" "Needs to be decreased"

For the initial assessment, list specific assistance needed in addition to what is already in place. Be specific about the task needed as well as the needed frequency. Assistance needed applies only to a true need, not merely a desire. For reassessment, indi- cate if present services are adequate or if they need to be increased or decreased.

For example: ***"Adequate" "Needs Increased to 3xwk" " Needs Decreased to 1xwk" "Caregiver is returning to work." "Now able to complete on own" "Health Deteriorating"***

Service Plan implications: *Remember any special circumstances (feeding, choking hazard, etc.) must be specified in the care plan to clearly indicate the special need and steps to safely meet the need.*

6. Transferring

Tell the member: ***"Transferring refers to the action of getting into and out of a tub, bed, chair, sofa, vehicle, etc.."***
Would you say you "need no assistance" "some assistance/supervision" or " Can't do at all"

Read the level of assistance choices (and definitions as necessary) before obtaining the member's answer. Place the score into the appropriate column corresponding to the member's response. If the member indicates he/she needs no assistance, document how he/ she is meeting the task. If the member indicates he/she needs some assistance/ supervision or can't do the activity at all, complete all remaining areas assigned to that task.

Comments: Remember to document strengths and needs, including unmet needs, indicating the specific assistance needed **and** why the assistance is needed. Indicate who assists and how the member manages when formal assistance is not available. What happens on the weekend?
For example: ***"Can get in and out of bed or chair, but needs assistance with bathtub due to fear of falling." "Could complete tub transfers with use of shower chair" "Needs assist transferring into wheelchair but able to move self around as needed"***

Name and phone number of assistant(s)
Document name and telephone numbers* of formal and informal supports.
*Phone numbers need only be entered once per page.

Assistant code/source
Identify the formal and informal supports using the assistant codes and/or appropriate identifying source provided.

Frequency, hours, etc
Indicate how long (hours) and often (daily, weekly, monthly, etc.) the member is receiving assistance from the support(s) listed.

For example: ***"7xweek, 3xweek, every day (QD), 1hr per week, 1xmonth, etc."***

Assistance needed
Identify the current assistance the member is receiving as:
"Adequate" "Needs to be increased" "Needs to be decreased"

For the initial assessment, list specific assistance needed in addition to what is already in place. Be specific about the task needed as well as the needed frequency. Assistance needed applies only to a true need, not merely a desire.

For reassessment, indicate if present services are adequate or if they need to be increased or decreased. For example: ***"Adequate" "Needs Increased to 3xwk" " Needs Decreased to 1xwk" "Caregiver is returning to work." "Now able to complete on own" "Health Deteriorating"***

Service Plan implications: *Remember any special circumstances must be specified in the care plan to clearly indicate the special need and steps to safely meet the need. If the member lives alone or is left alone and is unable to transfer independently, safety implications such as emergency evacuation must be addressed in the plan of care.*

7. Mobility

Tell the member: ***"This refers to your ability to move about even with the use of a cane, walker or wheelchair."***

Independence in mobility refers to walking or moving short distances. Independence does not include the ability to use stairs. For purposes of this document, It is considered assistance needed only if a member would not be mobile without the help of another person.

"Would you say you "need no assistance" "some assistance/supervision" or " Can't do at all"

A history of falls can be noted here to justify needed assist and/or assistive devices. Falls are addressed and scored in the Health Assessment section. Read the level of assistance choices (and definitions as necessary) before obtaining the member's answer. Place the score into the appropriate column corresponding to the member's response. If the member indicates he/she needs no assistance, document how he/she is meeting the task. If the member indicates he/she needs some assistance/ supervision or can't do the activity at all, complete all remaining areas assigned to that task.

Comments: Remember to document strengths and needs, including unmet needs, indicating the specific assistance needed **and** why the assistance is needed. Indicate who assists and how the member manages when formal assistance is not available. What happens on the weekend?

For example: ***"Can uses a walker but needs someone to stand beside and be available to assist due to dizziness and unsteady gait" "Requires assist to stand from sitting position"***

Name and phone number of assistant(s)

Document name and telephone numbers* of formal and informal supports.

*Phone numbers need only be entered once per page.

Assistant code/source

Identify the formal and informal supports using the assistant codes and/or appropriate identifying source provided.

Frequency, hours, etc

Indicate how long (hours) and often (daily, weekly, monthly, etc.) the member is receiving assistance from the support(s) listed.

For example: ***"7xweek, 3xweek, every day (QD), 1hr per week, 1xmonth, etc."***

Assistance needed

Identify the current assistance the member is receiving as:

"Adequate" ***"Needs to be increased"*** ***"Needs to be decreased"***

For the initial assessment, list specific assistance needed in addition to what is already in place. Be specific about the task needed as well as the needed frequency. Assistance needed applies only to a true need, not merely a desire.

For reassessment, indicate if present services are adequate or if they need to be increased or decreased. For example: ***"Adequate" "Needs Increased to 3xwk" " Needs Decreased to 1xwk" "Caregiver is returning to work." "Now able to complete on own" "Health Deteriorating"***

Level of care and Service Plan implications: Remember any special circumstances (needs reminders to use walker, cannot reach sink so needs water left at chair side, etc.) must be specified in the care plan to clearly indicate the special need and steps to safely meet the need. A negotiated risk document within the care plan may be appropriate if the member is unable to evacuate in an emergency situation. Document in the Summary and Comments Section any needs for a Fall Protocol. Remember, members at risk for nursing home placement are at a higher risk for falls than the general population. If you are concerned that a member cannot move about without assistance and has no assistance available when program services are out of home the administrative agent (OKDHS or OHCA) needs to be notified to make sure the member meets established Program Eligibility criteria. If the member is in immediate danger related to mobility issues, an Adult Protective Services Referral is to be initiated.

8. Stairs

Tell the member: ***"The intent is to determine if the use of stairs creates a barrier to meeting your ADL's or IADL's."***

Ask the member: ***"Do you encounter stairs that affect your daily activities three or more times per week, in your home or in the community?"***

Would you say you "need no assistance" "some assistance/supervision" or " Can't do at all"

This item refers to the ability to perform the task. If however, the individual lives in a situation that does *not* require him/her to encounter stairs routinely three or more times a week, score the item as '0' for purposes of this document.

Read the level of assistance choices (and definitions as necessary) before obtaining the member's answer. Place the score into the appropriate column corresponding to the member's response. If the member indicates he/she needs no assistance, document how he/she is meeting the task. If the member indicates he/she needs some assistance/ supervision or can't do the activity at all, complete all remaining areas assigned to that task.

Comments: Remember to document strengths and needs, including unmet needs, indicating the specific assistance needed **and** why the assistance is needed. Indicate who assists and how the member manages when formal assistance is not available. What happens on the weekend? For example: ***"Needs assist 5xwk with porch steps when leaving home to attend Adult Day Health"***

Name and phone number of assistant(s)

Document name and telephone numbers* of formal and informal supports.

*Phone numbers need only be entered once per page.

Assistant code/source

Identify the formal and informal supports using the assistant codes and/or appropriate identifying source provided.

Frequency, hours, etc

Indicate how long (hours) and often (daily, weekly, monthly, etc.) the member is receiving assistance from the support(s) listed.

For example: ***"7xweek, 3xweek, every day (QD), 1hr per week, 1xmonth, etc."***

Assistance needed

Identify the current assistance the member is receiving as:

"Adequate" "Needs to be increased" "Needs to be decreased"

For the initial assessment, list specific assistance needed in addition to what is already in place. Be specific about the task needed as well as the needed frequency. Assistance needed applies only to a true need, not merely a desire. For reassessment, indicate if present services are adequate or if they need to be increased or decreased.

For example: ***"Adequate" "Needs Increased to 3xwk" " Needs Decreased to 1xwk" "Caregiver is returning to work." "Now able to complete on own" "Health Deteriorating"***

Service Plan implications: Remember any special circumstances (gate to stairway must always remain closed, etc.) must be specified in the care plan to clearly indicate the special need and steps to safely meet the need.

9. Toileting

Tell the member: ***"The intent is to determine if you are able to use the toilet by yourself. This includes recognizing the urge to go, getting to the toilet, adjusting your clothing, getting on and off the toilet and keeping yourself clean and dry."***

For purposes of this document, if incontinence or bowel or bladder occurs and the member can manage to correct the problem in order to stay clean and dry without any assistance; toileting is considered independent. If the member has to be reminded to use the toilet, toileting is considered to need some assist/supervision. If the member does not or cannot change soiled clothing and wash skin to avoid urine and fecal smells, a needs assist/supervision is documented. Read the level of assistance choices (and definitions as necessary) before obtaining the member's answer. Place the score into the appropriate column corresponding to the member's response. If the member indicates he/she needs no assistance, document how he/she is meeting the task. If the member indicates he/she needs some assistance/ supervision or can't do the activity at all, complete all remaining areas assigned to that task.

Comments: Remember to document strengths and needs, including unmet needs, indicating the specific assistance needed **and** why the assistance is needed. Indicate who assists and how the member manages when formal assistance is not available.

What happens on the weekend? For example: ***"Can get on and off the toilet, but due to stiffness in hands and back needs assistance with cleaning and adjusting clothing" "Requires re minders to go to toilet" "Has difficulty getting to the bathroom in time after taking a water pill." "Can stay clean and dry during day but unable to control at night"***

Name and phone number of assistant(s)

Document name and telephone numbers* of formal and informal supports.

*Phone numbers need only be entered once per page.

Assistant code/source

Identify the formal and informal supports using the assistant codes and/or appropriate identifying source provided.

Frequency, hours, etc

Indicate how long (hours) and often (daily, weekly, monthly, etc.) the member is receiving assistance from the support(s) listed.

For example: ***"7xweek, 3xweek, every day (QD), 1hr per week, 1xmonth, etc."***

Assistance needed

Identify the current assistance the member is receiving as:

"Adequate" "Needs to be increased" "Needs to be decreased"

For the initial assessment, list specific assistance needed in addition to what is already in place. Be specific about the task needed as well as the needed frequency. Assistance needed applies only to a true need, not merely a desire. For reassessment, indicate if present services are adequate or if they need to be increased or decreased. For example: ***"Adequate" "Needs Increased to 3xwk" " Needs Decreased to 1xwk""Caregiver is returning to work." "Now able to complete on own" "Health Deteriorating"***

Service Plan implications: *Remember any special circumstances (has history of skin ulcers due to incontinence so must have at least partial bath every day, etc.) must be specified in the care plan to clearly indicate the special need and steps to safely meet the need.*

10. Bladder/Bowel Control

Tell the member: ***"The intent of this question is to determine the frequency of Bladder/Bowel Accidents that you have on a regular basis. "***

NOTE: For purposes of this document, an accident is defined as the inability of the body to control evacuation of urine or feces severe enough to soak through undergarments, clothing or bedding onto the skin with or without the use of an incontinent appliance or training program.

Ask the member: "***How often do you have a bowel or bladder accident that leaks or soaks through your undergarments, clothing or bedding onto your skin?"***

This item evaluates a functional ability and *scores differently from the other ADL items.* The only entry for bladder/bowel control is a score of 0-2-3 or 4 indicating frequency of accidents. No comments or assistance entries are made. For purposes of this document, dribbling, leakage or incontinence that does not soak through undergarments, clothing, bedding or incontinent appliance does not indicate an 'Accident'. A member may have incontinence and use pads, briefs or a catheter, however, if the appliance is able to contain the urine or feces, the occurrence is not counted as an accident.

Definition of Answers: Using the following "Definitions of Answers", enter the score that corresponds to the member's response.

Definition of Answers

Give a score of 0 for Never Have Accidents:

Bowel and/or Bladder = complete control or 0 accidents per week

Count 0 also if control is achieved by an appliance or training program.

"appliances" include external/condom catheters, indwelling catheters, ostomies, and other equipment or devices like pads/briefs, bedpans, urinals

"bowel/bladder training programs" include any scheduled toileting plan, intermittent use of catheters, and enemas or irrigation

Give a score of 2 for Occasionally:

Bladder = 2 or more accidents per week, but not daily

Bowel = 1 or less accidents per week

Give a score of 3 for Often:

Bladder = 1 daily episode of incontinence, even if some control is present i.e., continent during the daytime but 1 accident at night) Bowel = 2 - 3 accidents per week

Give a score of 4 for Always:

Bladder = 2 or more daily episodes (day or night)

Bowel = 1 accident daily (all/almost all of the time)

Health Risks and Complications: Health risks and complications associated with incontinence are identified in the Health Conditions section and scored based on clinical judgment criteria. Since incontinence carries a high risk of skin breakdown and infection and a frequent reason for nursing home admission, the Health Conditions section must be thoroughly probed and reviewed for related problems and the use of devices to manage them. The review includes decubiti, bladder/kidney problems, constipation, dehydration, skin conditions, medication use, recent hospital or doctor visits and reason, issues like bowel and bladder rehab, impaction, etc..

Service Plan implications: There can be multiple service plan implications regarding toileting, bowel/accidents, and use of appliances or training programs. A urine or fecal odor on a member or in the home is never "normal" and must always be investigated and resolved. Risk for falls, social isolation and depression, unmet medical needs, infection and skin integrity are critical issues that may need to be explored. For instance, if a member is hurrying to get to the bathroom or leaking on the way to the bathroom, he/she is at a greater risk for falls. Methods of minimizing the risk will need to be addressed for service planning. Consider questions like, "Does the member need to see a doctor to determine the reason for leaking?" "Do medications need to be adjusted?" "Would a bedside commode be helpful?" "Is the member embarrassed to have visitors or afraid to leave the house because of accidents?" "Does the member have frequent or chronic urinary tract infections?" "Are there signs of skin inflammation or breakdown?" "Are there community resources, like an ostomy association that would provide information and support?"

There may be cultural preferences to consider as well. What is the member's normal pattern of elimination? Are alternative products or home remedies used? Do assistants need to be of the same gender? Are only certain members of a family allowed to assist? Are certain practices prohibited?

These are often difficult issues for members to discuss and it is important to make the member as comfortable as possible. Emphasize the goal is to help the member resolve any problems he/she may be having. Also be sensitive to the member's need for privacy, especially if there are others in the home the member may not want included in the discussion.

11. Incontinent Supplies/Appliances Training

Ask the member, ***"Do you use pads or briefs? Do you use any appliance like a bedside commode, bedpan or urinal, catheter or ostomy supplies? Do you follow a bowel and/or bladder training program?"***

Ask only those questions that might apply to the member. If the Health Assessment has been completed, transfer the applicable information from the "Special Equipment/ Assistive Devices" and/or "Medical Treatments and Therapies" without repeating these questions to the member. Check **YES** or **NO** to use of incontinent supplies, appliance or training programs. If the member answers "**Yes**" identify the type of incontinent supplies, appliances or training programs used and specify type of appliance/ training program. Also use this area to document if member is going without needed supplies to manage incontinence. If member answers "**No**", move to next ADL. Answers to this item hold no score. No comments or assistance entries are made.

12. Assistance

Ask the member: ***"Do you need assistance with changing pads, appliances, or managing training program?" or "How have you been managing your incontinence and accidents?"***

Explore for assistance needed with any incontinent supplies such as pads, briefs, pull-ups; appliances such as urinal, bedpan, catheter, ostomy supplies; and interventions such as enemas, irrigations, bowel or bladder program and/or any scheduled toileting plan.

Enter the score into the appropriate column that corresponds to the member's response. If the member indicates no assistance needed, enter a score of "0". If some assistance/supervision is required, enter a score of "2". If unable to do at all, enter a score of "3".

Comments: Remember to document strengths and needs, including unmet needs, indicating the specific assistance needed **and** why the assistance is needed. Indicate who assists and how the member manages when formal assistance is not available. What happens on the weekend?

For example: ***"Needs assist due to dizziness and loss of balance when bending over to change briefs" "Requires assist with bowel stimulation every other day"***
"Needs assist changing briefs each morning related to inability to get out of bed."
"Due to paralysis, needs daily assistance with stoma care and emptying ostomy bag."

Name and phone number of assistant(s)

Document name and telephone numbers* of formal and informal supports.
*Phone numbers need only be entered once per page.

Assistant code/source

Identify the formal and informal supports using the assistant codes and/or appropriate identifying source provided.

Frequency, hours, etc

Indicate how long (hours) and often (daily, weekly, monthly, etc.) the member is receiving assistance from the support(s) listed.

For example: ***"7xweek, 3xweek, every day (QD), 1hr per week, 1xmonth, etc."***

Assistance needed

Identify the current assistance the member is receiving as:
"Adequate" "Needs to be increased" "Needs to be decreased"

For the initial assessment, list specific assistance needed in addition to what is already in place. Be specific about the task needed as well as the needed frequency. Assistance needed applies only to a true need, not merely a desire. For reassessment, indicate if present services are adequate or if they need to be increased or decreased. For example: ***"Adequate" "Needs Increased to 3xwk" " Needs Decreased to 1xwk"***
"Caregiver is returning to work." "Now able to complete on own" "Health Deteriorating".

Service Plan implications: *Remember any special circumstances (needs reminders to change Depends, etc.) must be specified in the care plan to clearly indicate the special need and steps to safely meet the need.*

Scoring ADLs

ADL Score

1. Add together all scores of 2 or more indicating the member needs some assistance or supervision or can't do the activity at all.
2. Add the score for bladder/bowel accidents in #10.
3. Record the sum of these items in the ADL Total Score Box.

Impairment Count

1. Count the number of items (impairments) with scores of 2 or more indicating the member needs some assistance or supervision, or can't do the activity at all.
2. Record the number of items indicating impairment in the ADL Impairment Count Box.

13. Answering the Telephone

Ask the member: ***"Can you answer the telephone and respond to the caller without the assistance of another person?"***

This activity includes identifying the ring, picking up the phone, responding effectively to the caller. It also includes the appropriate use of special equipment or assistive devices such as amplifiers or lights of a TDD system. Do not assign a score of 'cannot do activity at all' if the member does not have a phone but has the ability to answer a phone if present..

Read the level of assistance choices (and definitions as necessary) before obtaining the member's answer. Place the score into the appropriate column corresponding to the member's response. If the member indicates he/she needs no assistance, document how he/she is meeting the task. If the member indicates he/she needs some assistance/ supervision or can't do the activity at all, complete all remaining areas assigned to that task.

Comments: Remember to document strengths and needs, including unmet needs, indicating the specific assistance needed **and** why the assistance is needed. Indicate who assists and how the member manages when formal assistance is not available. What happens on the weekend? For example: ***"Recognizes the ring and can respond appropriately, but due to slow mobility, is often unable to get to the phone in time." "Unable to hearing related to hearing loss." "Relies completely on other family members to answer the phone."***

Name and phone number of assistant(s)

Document name and telephone numbers* of formal and informal supports.

*Phone numbers need only be entered once per page.

Assistant code/source

Identify the formal and informal supports using the assistant codes and/or appropriate identifying source provided.

Frequency, hours, etc

Indicate how long (hours) and often (daily, weekly, monthly, etc.) the member is receiving assistance from the support(s) listed.

For example: ***"Ongoing, relies completely on other family members to answer the phone."***

Assistance needed

Identify the current assistance the member is receiving as:

"Adequate" ***"Needs to be increased"*** ***"Needs to be decreased"***

For the initial assessment, list specific assistance needed in addition to what is already in place. Be specific about the task needed as well as the needed frequency. Assistance needed applies only to a true need, not merely a desire. For reassessment, indicate if present services are adequate or if they need to be increased or decreased. For example: ***"Adequate" "Needs special equipment related to hearing loss."***

Service Plan implications: *Remember any special circumstances must be specified in the care plan to clearly indicate the special need and steps to safely meet the need.* If a member is unable to answer or make a telephone call independently, service planning may need to include the feasibility of using special equipment/assistive devices such as amplifiers, magnifiers, enlarged key pads, programmable features, cordless telephones, and TDD systems.

14. Making a Telephone Call

Ask the member:

"Are you able to make a telephone call without the assistance of another person?"

Making a telephone call includes selecting the telephone number, dialing, effectively communicating with the person being called, and appropriate use of special equipment/ assistive devices such as large key pads, amplifiers, or TDD systems.

Read the level of assistance choices (and definitions as necessary) before obtaining the member's answer. Place the score into the appropriate column corresponding to the member's response. If the member indicates he/she needs no assistance, document how he/ she is meeting the task. If the member indicates he/she needs some assistance/ supervision or can't do the activity at all, complete all remaining areas assigned to that task.

Comments: Remember to document strengths and needs, including unmet needs, indicating the specific assistance needed **and** why the assistance is needed. Indicate who assists and how the member manages when formal assistance is not available. What happens on the weekend?

For example: ***""Can communicate effectively, but due to low vision, needs assistance looking up and dialing telephone numbers."***

Name and phone number of assistant(s)

Document name and telephone numbers* of formal and informal supports.

*Phone numbers need only be entered once per page.

Assistant code/source

Identify the formal and informal supports using the assistant codes and/or appropriate identifying source provided.

Frequency, hours, etc

Indicate how long (hours) and often (daily, weekly, monthly, etc.) the member is receiving assistance from the support(s) listed.

For example:

"7xweek, 3xweek, every day (QD), 1hr per week, 1xmonth, etc."

Assistance needed

Identify the current assistance the member is receiving as:

"Adequate" ***"Needs to be increased"*** ***"Needs to be decreased"***

For the initial assessment, list specific assistance needed in addition to what is already in place. Be specific about the task needed as well as the needed frequency. Assistance needed applies only to a true need, not merely a desire.

For reassessment, indicate if present services are adequate or if they need to be increased or decreased.

For example: ***"Adequate" "Needs programmed calling system for independence"***

Service Plan implications: *Remember any special circumstances (Has no source to contact emergency help, telephone must be left at chair side any time member is left alone, etc.) must be specified in the care plan to clearly indicate the special need and steps to safely meet the need.*

15. Shopping/Errands

Ask the member:

"Do you need any help shopping for food or other household or personal items?"

Shopping/Errands refers to making lists, selecting needed items, reading labels, reaching shelves, completing the purchase, and getting items home. It does not include transportation to and from the store which will be evaluated in IADL #16, Transportation Ability, for purposes of this document.

Read the level of assistance choices (and definitions as necessary) before obtaining the member's answer. Place the score into the appropriate column corresponding to the member's response. If the member indicates he/she needs no assistance, document how he/she is meeting the task. If the member indicates he/she needs some assistance/ supervision or can't do the activity at all, complete all remaining areas assigned to that task.

Comments: Remember to document strengths and needs, including unmet needs, indicating the specific assistance needed **and** why the assistance is needed. Indicate who assists and how the member manages when formal assistance is not available. What happens on the weekend? For example: ***"Can make a list but due to shortness of breath and weakness, needs an assistant to complete shopping." "Can ride cart but requires assist getting items off shelf and into cart due to neck/back pain"***

Name and phone number of assistant(s)

Document name and telephone numbers* of formal and informal supports.

*Phone numbers need only be entered once per page.

Assistant code/source

Identify the formal and informal supports using the assistant codes and/or appropriate identifying source provided.

Frequency, hours, etc

Indicate how long (hours) and often (daily, weekly, monthly, etc.) the member is receiving assistance from the support(s) listed.

For example: ***" Family assist 2 month." PCA assist 1x week"***

Assistance needed

Identify the current assistance the member is receiving as:

"Adequate" "Needs to be increased" "Needs to be decreased"

For the initial assessment, list specific assistance needed in addition to what is already in place. Be specific about the task needed as well as the needed frequency. Assistance needed applies only to a true need, not merely a desire.

For reassessment, indicate if present services are adequate or if they need to be increased or decreased.

For example: ***"Adequate" "Needs additional help as family has moved out of state."***

Service Plan implications: *Remember any special circumstances (shopping for groceries needs to adhere to strict dietary requirement to reduce salt consumption, etc.) must be specified in the care plan to clearly indicate the special need and steps to safely meet the need.*

16. Transportation Ability

Ask the member: ***"Are you able to drive or arrange for transportation when you need to go somewhere?"***

Transportation ability is defined as driving, or arranging and using private or public transportation services to go to places beyond walking distance. It does not refer to the member's ability to get to a vehicle or to the member's ability to get in and out of a vehicle. These tasks were already assessed in the ADL Section under Mobility and Transferring.

Read the level of assistance choices (and definitions as necessary) before obtaining the member's answer. Place the score into the appropriate column corresponding to the member's response. If the member indicates he/she needs no assistance, document how he/she is meeting the task. If the member indicates he/she needs some assistance/ supervision or can't do the activity at all, complete all remaining areas assigned to that task.

Comments: Remember to document strengths and needs, including unmet needs, indicating the specific assistance needed **and** why the assistance is needed. Indicate who assists and how the member manages when formal assistance is not available. What happens on the weekend?

For example: ***"Due to cognitive effects of stroke, member cannot arrange for needed transportation"***

Name and phone number of assistant(s)

Document name and telephone numbers* of formal and informal supports.

*Phone numbers need only be entered once per page.

Assistant code/source

Identify the formal and informal supports using the assistant codes and/or appropriate identifying source provided.

Frequency, hours, etc

Indicate how long (hours) and often (daily, weekly, monthly, etc.) the member is receiving assistance from the support(s) listed.

Neighbor calls Bus 1xweek" "PCA assist 1x week with making needed Dr. appointments."

Assistance needed

Identify the current assistance the member is receiving as:

"Adequate" "Needs to be increased" "Needs to be decreased"

For the initial assessment, list specific assistance needed in addition to what is already in place. Be specific about the task needed as well as the needed frequency. Assistance needed applies only to a true need, not merely a desire. For reassessment, indicate if present services are adequate or if they need to be increased or decreased. For Example: ***"Will need someone to assist in finding transportation to chemotherapy beginning next month."***

Service Plan implications: *Remember any special circumstances (daughter needs to arrange Dr. appointments around her work schedule, etc.) must be specified in the care plan to clearly indicate the special need and steps to safely meet the need.*

17. Prepare Meals

Ask the member, ***"Can you fix simple meals like a sandwich, bowl of cereal, or TV dinner so that you won't go hungry?"***

Read the level of assistance choices (and definitions as necessary) before obtaining the member's answer. Place the score into the appropriate column corresponding to the member's response. If the member indicates he/she needs no assistance, document how he/ she is meeting the task. If the member indicates he/she needs some assistance/ supervision or can't do the activity at all, complete all remaining areas assigned to that task.

NOTE: Scoring for this task does not refer to quality of nutritional content for purposes of this document.

Comments: Remember to document strengths and needs, including unmet needs, indicating the specific assistance needed **and** why the assistance is needed. Indicate who assists and how the member manages when formal assistance is not available. What happens on the weekend?

For example: ***"Due to paraplegia, Ms. Smith is able to prepare simple meals , adapting the preparation by sitting at the table instead of standing at the counter".***

Name and phone number of assistant(s)

Document name and telephone numbers* of formal and informal supports.

*Phone numbers need only be entered once per page.

Assistant code/source

Identify the formal and informal supports using the assistant codes and/or appropriate identifying source provided.

Frequency, hours, etc

Indicate how long (hours) and often (daily, weekly, monthly, etc.) the member is receiving assistance from the support(s) listed. For example:

Neighbor brings Sunday dinner over every week." "PCA assist with advance meal preparation 2x weekly."

Assistance needed

Identify the current assistance the member is receiving as:

"Adequate" ***"Needs to be increased"*** ***"Needs to be decreased"***

For the initial assessment, list specific assistance needed in addition to what is already in place. Be specific about the task needed as well as the needed frequency. Assistance needed applies only to a true need, not merely a desire. For reassessment, indicate if present services are adequate or if they need to be increased or decreased.

For example: ***"Meals on Wheels will begin next week so PCA assistance with meal preparation is no longer required."***

Service Plan implications: *Remember any special circumstances (advance meal preparation, does not eat pork etc.) must be specified in the care plan to clearly indicate the special need and steps to safely meet the need. Home delivered meals may be a more cost effective means of supplying a meal in many situations, however, would the PCA 's presence to prepare and serve a meal be better to reduce social isolation and promote safety? Meals are only provided to members who are unable to prepare meals and lack an informal support to prepare the meals.*

18. Laundry

Ask the Member,

"Are you able to do your laundry?"

Read the level of assistance choices (and definitions as necessary) before obtaining the member's answer. Place the score into the appropriate column corresponding to the member's response. If the member indicates he/she needs no assistance, document how he/she is meeting the task. If the member indicates he/she needs some as assistance/ supervision or can't do the activity at all, complete all remaining areas assigned to that task.

Comments: Remember to document strengths and needs, including unmet needs, indicating the specific assistance needed **and** why the assistance is needed. Indicate who assists and how the member manages when formal assistance is not available. What happens on the weekend?

For example: ***"Can sort, fold, and put clothes away, but does not have the strength to carry items to the Laundromat."***

Name and phone number of assistant(s)

Document name and telephone numbers* of formal and informal supports.

*Phone numbers need only be entered once per page.

Assistant code/source

Identify the formal and informal supports using the assistant codes and/or appropriate identifying source provided.

Frequency, hours, etc

Indicate how long (hours) and often (daily, weekly, monthly, etc.) the member is receiving assistance from the support(s) listed. For example:

"PCA assist 1x week to do laundry while also completing other housekeeping tasks."

Assistance needed

Identify the current assistance the member is receiving as:

"Adequate" ***"Needs to be increased"*** ***"Needs to be decreased"***

For the initial assessment, list specific assistance needed in addition to what is already in place. Be specific about the task needed as well as the needed frequency. Assistance needed applies only to a true need, not merely a desire. For reassessment, indicate if present services are adequate or if they need to be increased or decreased.

For example: ***"Member is now living with her daughter. Laundry will be completed along with the family laundry and no longer needs PCA assist."***

Service Plan implications: *Remember any special circumstances (Laundromat is 20 miles from home etc.) must be specified in the care plan to clearly indicate the special need and steps to safely meet the need.*

19. Light Housekeeping

Ask the member,

"Are you able to do light housekeeping chores like washing dishes, dusting, vacuuming, sweeping, mopping, and cleaning the bathroom?"

This item refers to light housekeeping tasks necessary to clean the areas of the home the member uses (i.e. living room, bedroom, bathroom, and kitchen). It does not include areas used solely by someone else (i.e. other people's bedrooms, bathroom, or living space the member does not use).

Read the level of assistance choices (and definitions as necessary) before obtaining the member's answer. Place the score into the appropriate column corresponding to the member's response. If the member indicates he/she needs no assistance, document how he/she is meeting the task. If the member indicates he/she needs some assistance/ supervision or can't do the activity at all, complete all remaining areas assigned to that task.

Comments: Remember to document strengths and needs, including unmet needs, indicating the specific assistance needed **and** why the assistance is needed. Indicate who assists and how the member manages when formal assistance is not available. What happens on the weekend?

For example: ***"Can dust and sweep, but due to decreased stamina, needs assistance with all other tasks."***

Name and phone number of assistant(s)

Document name and telephone numbers* of formal and informal supports.

*Phone numbers need only be entered once per page.

Assistant code/source

Identify the formal and informal supports using the assistant codes and/or appropriate identifying source provided.

Frequency, hours, etc

Indicate how long (hours) and often (daily, weekly, monthly, etc.) the member is receiving assistance from the support(s) listed.

For example: ***"2xweek, 1hr per week, 1xmonth, etc."***

Assistance needed

Identify the current assistance the member is receiving as:

"Adequate" ***"Needs to be increased"*** ***"Needs to be decreased"***

For the initial assessment, list specific assistance needed in addition to what is already in place. Be specific about the task needed as well as the needed frequency. Assistance needed applies only to a true need, not merely a desire. For reassessment, indicate if present services are adequate or if they need to be increased or decreased.

For example: ***"Adequate" "Sister is unable to continue helping with cleaning floors so needs are increased by 1 hour weekly."***

Service Plan implications: *Remember any special circumstances (vacuuming is needed 2x weekly due to severe allergies, etc.) must be specified in the care plan to clearly indicate the special need and steps to safely meet the need. When meal preparation is included in the plan, washing dishes is part of the meal prep task. When bathing assistance is included in the plan, much of the bathroom is cleaned as part of that task.*

20. Heavy Chores

Ask the member, ***"Are you able to do heavy chores like washing windows, moving furniture, home repairs, and yard work?"***

Read the level of assistance choices (and definitions as necessary) before obtaining the member's answer. Place the score into the appropriate column corresponding to the member's response. If the member indicates he/she needs no assistance, document how he/she is meeting the task. If the member indicates he/she needs some assistance/ supervision or can't do the activity at all, complete all remaining areas assigned to that task.

Comments: Remember to document strengths and needs, including unmet needs, indicating the specific assistance needed **and** why the assistance is needed. Indicate who assists and how the member manages when formal assistance is not available. What happens on the weekend?
For example: ***"Can't do at all due to the effects of COPD."***

Name and phone number of assistant(s)
Document name and telephone numbers* of formal and informal supports.
*Phone numbers need only be entered once per page.

Assistant code/source
Identify the formal and informal supports using the assistant codes and/or appropriate identifying source provided.

Frequency, hours, etc
Indicate how long (hours) and often (daily, weekly, monthly, etc.) the member is receiving assistance from the support(s) listed.

For example: ***"7xweek, 3xweek, every day (QD), 1hr per week, 1xmonth, etc."***

Assistance needed
Identify the current assistance the member is receiving as:
"Adequate" "Needs to be increased" "Needs to be decreased"

For the initial assessment, list specific assistance needed in addition to what is already in place. Be specific about the task needed as well as the needed frequency. Assistance needed applies only to a true need, not merely a desire.

For reassessment, indicate if present services are adequate or if they need to be increased or decreased.

For example: ***"Adequate" "Lives in apartment complex that includes this service in rent."***

Service Plan implications: *Remember any special circumstances (has large hole in kitchen floor, etc.) must be specified in the care plan to clearly indicate the special need and steps to safely meet the need.*

21. Taking Medications

Ask the member,

"Do you need help to take your medications?"

This question includes the ability to set up, remember, and take one's medications as prescribed.

Read the level of assistance choices (and definitions as necessary) before obtaining the member's answer. Place the score into the appropriate column corresponding to the member's response. If the member indicates he/she needs no assistance, document how he/she is meeting the task. If the member indicates he/she needs some assistance/ supervision or can't do the activity at all, complete all remaining areas assigned to that task.

Comments: Remember to document strengths and needs, including unmet needs, indicating the specific assistance needed **and** why the assistance is needed. Indicate who assists and how the member manages when formal assistance is not available. What happens on the weekend?

For example: ***"Can take medications, but due to cognitive limitations, needs reminders."***

Name and phone number of assistant(s)

Document name and telephone numbers* of formal and informal supports.

*Phone numbers need only be entered once per page.

Assistant code/source

Identify the formal and informal supports using the assistant codes and/or appropriate identifying source provided.

Frequency, hours, etc

Indicate how long (hours) and often (daily, weekly, monthly, etc.) the member is receiving assistance from the support(s) listed.

For example: ***"3x daily, 3xweek, every day (QD), 1hr per week, 1xmonth, etc."***

Assistance needed

Identify the current assistance the member is receiving as:

"Adequate" ***"Needs to be increased"*** ***"Needs to be decreased"***

For the initial assessment, list specific assistance needed in addition to what is already in place. Be specific about the task needed as well as the needed frequency. Assistance needed applies only to a true need, not merely a desire.

For reassessment, indicate if present services are adequate or if they need to be increased or decreased.

For example: ***"Adequate" "Medicare has discharged member, assistance is needed weekly."***

Service Plan implications: *Remember any special circumstances (needs daily reminders to take medication, etc.) must be specified in the care plan to clearly indicate the special need and steps to safely meet the need.*

22. Managing Money

Ask the member, ***"Do you need help paying your bills, balancing your checkbook, or staying within your budget?"***

Read the level of assistance choices (and definitions as necessary) before obtaining the member's answer. Place the score into the appropriate column corresponding to the member's response. If the member indicates he/she needs no assistance, document how he/she is meeting the task. If the member indicates he/she needs some assistance/ supervision or can't do the activity at all, complete all remaining areas assigned to that task.

Comments: Remember to document strengths and needs, including unmet needs, indicating the specific assistance needed **and** why the assistance is needed. Indicate who assists and how the member manages when formal assistance is not available. What happens on the weekend?

For example: ***"Can stay within budget, but due to severe arthritis, needs assistance writing checks."***

Name and phone number of assistant(s)

Document name and telephone numbers* of formal and informal supports.

*Phone numbers need only be entered once per page.

Assistant code/source

Identify the formal and informal supports using the assistant codes and/or appropriate identifying source provided.

Frequency, hours, etc

Indicate how long (hours) and often (daily, weekly, monthly, etc.) the member is receiving assistance from the support(s) listed.

For example:

"7xweek, 3xweek, every day (QD), 1hr per week, 1xmonth, etc."

Assistance needed

Identify the current assistance the member is receiving as:

"Adequate" "Needs to be increased" "Needs to be decreased"

For the initial assessment, list specific assistance needed in addition to what is already in place. Be specific about the task needed as well as the needed frequency. Assistance needed applies only to a true need, not merely a desire.

For reassessment, indicate if present services are adequate or if they need to be increased or decreased.

For example: ***"Adequate" "Now living with daughter so paying bills monthly is no longer needed from the PCA."***

Service Plan implications: *Remember any special circumstances (unable to physically write the checks, however, is able to sign once filled out, etc.) must be specified in the care plan to clearly indicate the special need and steps to safely meet the need.*

Scoring IADLs

IADL Score
1. Add together all scores of 2 or more indicating the member needs some assistance or supervision or can't do the activity at all.
2. Record the sum of these items in the IADL Total Score Box.

Impairment Count
1. Count the number of items (impairments) with scores of 2 or more indicating the member needs some assistance or supervision, or can't do the activity at all.
2. Record the number of items indicating impairment in the IADL Impairment Count Box.

The impairment count is completely separate from and not included in the total score.

Member Support and Social Resources Information

The following sections are included in Member Support and Social Resources.

1. Source of information
2. Member support
3. Living arrangements
4. Member support when sick
5. Plans for alternative living arrangement
6. Someone to talk to
7. Pets
8. Telephone contacts
9. Interaction with friends/relatives
10. Interests or activities
11. Attending religious services

Introduction

The intent of this section is to organize member support information and to assess the sufficiency of the support. The questions assist in evaluating the strengths, weaknesses, needs and challenges in the member's support system.

Member supports are generally described as either informal or formal.

Informal Support

Refers to services from family, friends, neighbors, churches, volunteers, and community organizations who don't get paid for their assistance.

Formal Support

Refers to services from individuals, agencies, programs, and organizations who do get paid for their assistance.

The distinction between the formal and informal supports is important for assessor/ case managers. Assessor/case managers will want to use all available informal resources and supports whenever possible before accessing formal resources and supports. In addition, all available formal supports are to be explored before using a waiver service. The intent of the waiver programs are to supplement, not replace, available informal and formal supports that can be used to assure the health and welfare of the member.

1. Source of Information

Indicate the source or sources of information used for completing this section. If the source is not the member, record the name of the source: first name, middle initial, and the last name.

2. Member Support

For each service listed, indicate if the member is currently receiving the service and if so, complete all sections for the service.

Level of care and Service Plan implications: Level of care and Comprehensive service planning requires assessor/case managers to identify and address all member unmet needs. Services offered by the program may not meet all of a member's needs or may not be the most appropriate choice when there are other resources available. Assessor/case managers can use the information obtained to help determine if the right service is being provided by the right provider, in the right amount, the right setting, and for the right price. The assessor/case manager will also want to assess if the service is providing the right outcome for the member with questions such as: Are you satisfied with this service? Is it helping? What do you like or dislike about this service? Thorough assessment of current services provides the Interdisciplinary Team (minimum of case manager, member, agency nurse) with valuable information about resources and payor sources, as well as, unmet member needs requiring the development of informal or formal supports.

Services from a Health Professional (RN, Therapist, Hospice, etc.)

Ask the member, ***"Are you currently receiving health services from a home health agency, private nurse, or therapist?"***

This item refers to any paid or unpaid professional health care services the member is receiving, such as nursing care, hospice, personal care assistance, physical or occupational therapy, respiratory therapy, or mental health services. It also includes health services a relative, friend, or neighbor might be providing, such as daily wound care. If the member indicates he/she does not receive a service, record "no" and go to the next service. Note: If the member answered "no" but has an unmet need for the services, make a note in the "assistance needed" column before continuing with the next service. If the member indicates he/she does receive services, record "yes" and complete all sections for this service.

Name and phone number of assistant(s)

Document name and telephone numbers* of formal and informal supports.

*Phone numbers need only be entered once per page.

Assistant code/source

Identify the formal and informal supports using the assistant codes and/or appropriate identifying source provided.

Frequency, hours, etc

Indicate how often the member is receiving assistance from the support(s) listed.

For example: ***"7xweek, 3xweek, every day (QD), 1hr per week, 1xmonth, etc."***

Assistance needed

Identify the current assistance the member is receiving as:

"Adequate" ***"Needs to be increased"*** ***"Needs to be decreased"***

For the initial assessment, list specific assistance needed in addition to what is already in place. Be specific about the task needed as well as the needed frequency. For reassessment, indicate if present services are adequate or if they need to be increased or decreased. If it is known a service may terminate, give the time frame if possible and recommendations for replacement service if they will be needed. If the current formal support is SPPC and it is recommended the member transition to AD*vantage*, please document how many units of care the member is receiving and the provider agency.

For example, ***"May need to increase PCA hours to 3x/wk when Medicare ends in two weeks."***

Service Plan implications*:* Alternate payor sources for skilled health services must be exhausted prior to waiver service authorization. Considerations for service planning include skilled nursing to perform a skilled service of a maintenance or preventive nature to members with stable health conditions including but not limited to: pre-filling medication planners and/or insulin syringes, monitoring skin condition for members at risk for breakdown, Diabetic nail care, health teaching of a specific and limited nature, skills training to member and/or family. It may also include the need for Hospice care or other therapies for eligible members. Medicare specifies when personal care can be provided, and is only allowed when a skilled need is also present.

Services from Adult Day Health Program

Ask the member,

"Do you attend an Adult Day Health Program?"

Adult Day Health (ADH) refers to a structured group program for older adults, in a licensed facility. It does not include Senior Centers and Nutrition Sites.

If the member indicates he/she does not receive a service, record "no" and go to the next service. Note: If the member answered "no" but has an unmet need for the services, make a note in the "assistance needed" column before continuing with the next service.

If the member indicates he/she does receive services, record "yes" and complete all sections for this service.

Name and phone number of assistant(s)

Document name and telephone numbers* of formal and informal supports.

*Phone numbers need only be entered once per page.

Assistant code/source

Identify the formal and informal supports using the assistant codes and/or appropriate identifying source provided.

Frequency, hours, etc

Indicate how often the member is receiving assistance from the support(s) listed.

For example:

"7xweek, 3xweek, every day (QD), 1hr per week, 1xmonth, etc."

Assistance needed

Identify the current assistance the member is receiving as:

"Adequate" ***"Needs to be increased"*** ***"Needs to be decreased"***

For the initial assessment, list specific assistance needed in addition to what is already in place. Be specific about the task needed as well as the needed frequency. For reassessment, indicate if present services are adequate or if they need to be increased or decreased. If adult day health is already in place, please document if the service needs to be included in the service plan with AD*vantage* as the payor source. If it is known a service may terminate, give the time frame if possible and recommendations for replacement service if they will be needed. For example,

"May need to increase ADH to 5x/wk when Caregiver returns to work in 3 weeks."

Service Plan implications: Consider this service to assist the caregiver that has to work or is in need of frequent respite from caregiving. It may be beneficial also for the socially isolated member.

Services from Other Types of Assistance

Ask the member,

"Do you receive any other kinds of services we haven't talked about?"

Other kinds of assistance includes services such as respite, yard work, home repairs, financial assistance, and transportation.

If the member indicates he/she does not receive a service, record "no" and go to the next service. Note: If the member answered "no" but has an unmet need for the services, make a note in "assistance needed" before continuing with the next service.

If the member indicates he/she does receive services, record "yes" and complete all sections for this service.

Name and phone number of assistant(s)

Document name and telephone numbers* of formal and informal supports.

*Phone numbers need only be entered once per page.

Assistant code/source

Identify the formal and informal supports using the assistant codes and/or appropriate identifying source provided.

Frequency, hours, etc

Indicate how often the member is receiving assistance from the support(s) listed.

For example:

"7xweek, 3xweek, every day (QD), 1hr per week, 1xmonth, etc."

Assistance needed

Identify the current assistance the member is receiving as:

"Adequate" ***"Needs to be increased"*** ***"Needs to be decreased"***

For the initial assessment, list specific assistance needed in addition to what is already in place. Be specific about the task needed as well as the needed frequency. For reassessment, indicate if present services are adequate or if they need to be increased or decreased. If it is known a service may terminate, give the time frame if possible and recommendations for replacement service if they will be needed. For example,

"Daughter relocating in one month, may need to seek alternative respite source."

Service Plan implications: Be sure to explore the need to locate sources for yard work, respite, etc.. These needs, not met, can lead to a premature need for institutionalization.

3—11 Social Resources

The questions in this section help identify people and activities that are important to the member. Family and friends can influence every aspect of a member's life, including physical health, emotional well-being, and living arrangements. Availability of social supports is often vital to the success of community living.

3. Member's Living Situation

Does the member live alone? This item is answered by the assessor/case manager without questioning the member unless the answer is in doubt. If the member lives alone, record "yes" and enter six (6) in the score box. If the member does not live alone, record "no" and enter zero (0) in the score box. Comments needed to aide in service planning include who the member lives with, if that person works outside the home and if that person is involved in the member's care.

Service Plan implications: When the member lives with others, lives in the same household as the PCA, or two or more AD*vantage* members reside together, the care plan is adjusted according to the support this provides. Services are not intended to take the place of regular care and general household maintenance tasks or meal preparation typically shared or done for one another by spouses or other adults living in the same household. Services are not furnished if they principally benefit the family unit as a whole. Services are included in the plan of care to enable the family and/or significant others to continue caregiving over extended periods. When the PCA and member live within the same household, personal care will only be approved by agreement of the IDT and the AA when the tasks are consistent with plan goals and have beneficial outcomes for the member. When others in the household are also on services, these services must be considered to avoid a duplication or excess of efforts. In extraordinary circumstances spouses and legal guardians are approved as paid caregivers in some programs. It is important for the assessor/case manager to document recommendations for/against a household member or legally responsible adult to act as the paid caregiver. The IDT determines and provides justification as to whether this will jeopardize or enhance the member's health and safety.

4. Sick Plan

Ask the member, ***"Is there someone who could stay with you if you needed it or if you were sick?"***

If the member indicates "no", record "no" and enter the score of six (6) in the score box. If the member indicates "yes", record "yes", enter a score of zero (0) in the score box and record the person's name, relationship to the member, complete address, and phone number, including area code.

5. Plans for Alternative Living Arrangements

Ask the member: ***"If you could no longer continue to live in your present location, do you have any ideas about where you would live?"***

Record the member's response.

a. If the member's response is similar to "I want to stay in my home until I die," check the space next to "home".

b. If the member's response involves a smaller home, apartment, or mobile home, record "smaller home", and note the member's explanation of where it might be located.

c. If a relative's home is the member's response, record the relative's name and the relationship; also ask whether this possibility has been discussed with the relative.

d. If the member does not understand what the other settings listed are, explain the services typically provided in those settings.

e. If a nursing home is the member's response, record "nursing home". If the member expresses a preference for a particular nursing home, document the name.

f. Ask the member to specify any other choices.

g. If the member does not know where he/she would go, record "don't know" and inform the member that assistance is available to help him/her explore possible options.

This question allows you to record the member's preference for alternative living arrangements if moving becomes necessary. This information will help you to explore future placement options for the member.

This is a natural place in the interview to discuss many service choices. The member may not be aware of alternatives available in the community. Use this opportunity to educate, as well as learn his/her preferences.

FREEDOM OF CHOICE for the member is a guiding tenant in explaining alternative living arrangements. The assessor/case manager has the opportunity and responsibility to educate about choices, but not influence those choices.

Service Plan implications: This question provides insight into whether or not a member has thought about or has made plans for his/her future. Life transition planning helps members plan ahead for major life changes before a crisis occurs. It is a process that guides delivery of a variety of services including, but not limited to, healthcare, long term care, education and career goals, legal and financial issues, insurance, burial wishes, and end-of-life care. Although life transition planning empowers the member to shape his/her own future, some subjects, like long term care, burial wishes, and end-of-life care can be difficult for people to talk about. Members may not be aware of alternatives available and assessor/case managers can use this opportunity to educate, as well as learn about the member's preferences. These discussions can occur over time as the relationship between the member and the assessor/case manager grows.

6. Person to Talk To

Ask the member, ***"Is there a person you can talk to when you have a problem?"***

If the member indicates "no", record "no" and enter the score of four (4) in the score box. If the member is willing to elaborate, probe to determine if the member chooses not to talk to others about his/her problems or if there are barriers such as limited circle of friends/family, distance, financial constraints (i.e. can't afford phone or transportation), physical limitations, etc. If the member indicates "yes", record "yes" and enter the score of zero (0) in the score box and record the person's name and relationship to the member. If a member answers, "I don't know", explore options such as friends, family, clergy, or counselor. If the member is then able to identify someone, follow the instructions for "yes". If the member is still not able to identify someone, follow the instructions for "no".

Service Plan implications: Some members may welcome having someone help them with problem solving and decision making. Others may feel uncomfortable sharing personal information. The challenge for assessor/ case managers is to determine whether a lack of friends or family to assist with problems or decision making is perceived as a concern to the member. If it is, the assessor/case manager can document the concern on the UCAT which alerts the Team to address the concern at the service planning IDT.

7. Pets

Ask the member, ***"Do you have a pet?"***

If the member indicates "no", record "no" and proceed to the next item. If the member indicates "yes", record "yes" and specify the type of pet(s). If the member indicates he/she wishes she had a pet, make a note in the Comments/ Service Plan Implications box before going to the next question.

Service Plan implications: This question is designed to help you determine whether a pet(s) may interfere with services because of aggressive or threatening behavior, flea infestation, disease, or the presence of defecation. Slip, trip and fall hazards should be considered. While service provision is limited to addressing "member needs", the assessor/case manager should explore with the member ways to meet pet care such as feeding, watering, cleaning up after, exercise, etc. using additional resources available. Consider the effects on the member if the pet dies or is removed from the member's home. Also, be aware that pets may be a social support and are as important to some members as grandchildren are to others.

8. Frequency of Contact With Others

Ask the member, ***"How often do you normally talk to friends, relatives, or others on the phone, they call you or you call them?"***

If needed, prompt the member by reading the choice of answers.

Record the member's response and place the corresponding score in the score box. Record the names and phone numbers of persons with whom the member has the most contact.

A space for comments is provided to add pertinent information such as whether or not the member is satisfied with the amount of contact. Communication barriers such as the member or significant contacts not having a phone or not being able to use a phone can also be noted.

This question helps you determine the member's level of social involvement, contact with others outside the home and potential for being (or becoming) socially isolated. Determine whether contact is initiated by the member or by friends, family or others.

9. Spending Time With Others

Ask the member, ***"How often do you spend time with someone who does not live with you, that is, you go to see them or they visit you, or you do things together, either in the home or out of the home?"***

If needed, prompt the member by reading the choice of answers. Record the member's response and place the corresponding score in the score box.
Record the names and phone numbers of persons with whom the member has the most contact.

A space for comments is provided to add pertinent information such as whether or not the member is satisfied with the amount of contact. Transportation barriers such as the member or significant contacts not having transportation available can be noted.

This question helps you determine the member's level of social involvement, contact with others outside the home and potential for being (or becoming) socially isolated. Determine whether contact is initiated by the member or by friends, family or others.

Service Plan implications: Learn what is important to the member. Some members may value an active social life while others may feel their privacy is threatened. Some cultures limit social contacts to small family or religiously based groups. While social isolation may have potential consequences on a person's ability to remain at home, it is nevertheless a member's choice. Assessor/case managers will need to determine if the behavior is based on preference or if it is based on circumstances or health conditions that might respond to intervention. For example, not having a telephone or access to transportation are circumstances that would need to be addressed in service planning. Health conditions like depression and incontinence can lead to isolation and may also have service plan implications that could be addressed by the Team. Comprehensive assessment includes probing for this kind of information to assure the member's needs and preferences are then supported by the comprehensive service plan. It may be appropriate to include a senior companion, caregiver or other support services in the care plan depending on the level of isolation.

10. Activities

Ask the member, *"What activities or interests do you enjoy?"*

Record the activities/interests in which the member currently participates. If needed, use prompts such as, "Do you go to the Senior Center? Did you make the ceramic vase I see on the table? Do you have a favorite TV show?" It is also helpful to ask the member if there are activities/interests he/she used to enjoy but feels he/she is no longer able to do.

11. Religious or Spiritual Participation

Ask the member, *"Are you able to attend services or practice your religious or spiritual beliefs as often as you would like?"*

If the member indicates he/she does not have an interest in religious or spiritual beliefs, record "NA" (not applicable) and do not pursue the subject.

If the member answers, "yes", indicating he/she is able to attend services or practice spiritual beliefs as often as desired, record "yes". Enter the name of the church/synagogue/mosque and the name of a contact person. Also, note if the member receives religious services at home and by whom.

If the member answers "no", indicating he/she is not able to attend religious services or practice spiritual beliefs as often as desired, record "no".

A **NOTES** space is provided to add pertinent information such as why the member is not able to attend religious services or practice spiritual beliefs as desired.

Service Plan implications: Religious or spiritual participation helps identify possible links with a religious organization as a resource to the member. It is helpful to understand the status of the member's social resources and activity involvement. Family and friends identified as resources can sometimes be approached to participate in the service plan. They can be included in "back-up" plans of service. When it is discovered that a member's social resources are limited, or nonexistent, this should be of concern and noted. As availability of informal support is vital to the success of community living, this could place the member at risk of institutionalization in the event of illness, or advancing disease processes. You will want to monitor persons with limited social resources more often, and assist them in developing some if possible. It's important to know what's important to the member. Some cultures limit social contacts to small family or religiously based groups. Some members may value an active social life while others feel their privacy is threatened. Some members may welcome counseling and intervention by clergy while others may be offended. If a member has social needs you can ask, "What kinds of activities are meaningful to you? Are there particular people or groups you would like to spend more time with? How would you feel about…?"

Social Resources Total Score

Domain scores assigned to his section are as follows:

Lives alone: Yes=(6), No=(0)
Has someone to stay with if sick: Yes= (0), No= (6)
Has someone to talk to about problems: Yes = (0), No = (4)
Frequency of phone contact:
Once a day or more (0)
2-6 x weekly (1) Once
weekly (2) 1-3 x a
month (3)
Less than once a month (4)
No phone (4)
Frequency of personal contact with others who don't live with member:
Once a day or more (0)
2-6 x weekly (1) Once
weekly (2) 1-3 x a
month (3)
Less than once a month (4)

The maximum possible score is 24.

Comments/Service Plan Implications
This space is provided for the assessor/case manager to document a brief summary of social resource items and may include personal goals. Document the member's perception of whether or not he/she feels socially isolated. Identify issues that need to be addressed by the Team, including lack of social supports, life transition planning, member preferences, cultural practices, and barriers to desired social contacts and activities. Include recommendations for community resources and other available resources that may be considered by the Team.

Service Plan implications: Personal goals are just about anything that motivates and may be achievable, i.e. go to church, volunteer, etc. In short, personal goals will be unique to the member. Personal goals need to be clearly defined/labeled and included in the plan of care. Include the member's realistic wants and desires; what he/she may have lost and wishes to regain in life and activities the member wants to participate in. While service provision is limited to addressing "needs", the assessor/case manager should explore with the member ways to meet personal goals using additional resources available.

Mental Health Assessment Information

There are seven items and three Comments/Service Plan Implication Boxes to be completed in this section.

l. Source of Information

2. Current Mental Health Problem

3. Currently or Previously Receiving Services

4. Emotional Well Being

5. Memory Assessment

6. Assessor Opinion of Member's Mental Health Status

7. Mental Health Assessment/Referral

Introduction

The purpose of the Mental Health Assessment is to capture a mental health history, memory, and current emotional well-being. This information assists the Assessor/Case Manager in making appropriate referrals to mental health services and gives clues to the behaviors of the individual that may affect service planning.

Members come from a variety of backgrounds and bring their own unique set of circumstances. There are:

those with highly developed coping skills, support systems and no apparent mental health issues.

- those who have lived with a chronic, severe mental health disorder all their lives, have been engaged in mental health treatment, may have been institutionalized in the past, and now live in the community.
- those who have lived with a chronic, severe mental health disorder all their lives, lived at home and were cared for by family.
- those who have lived with a less severe, but still chronically disabling mental health disorder all of their lives, and may or may not have ever been treated.
- those who are elderly and experience mental health problems for the first time as senior citizens. (Multiple losses - health, looks, money, loved ones, sense of identity with retirement, sense of purpose, connectedness with others, etc.).

those who are newly disabled and experience mental health problems for the first time due to their physical disability.

The assessor/case manager must be aware of the multiple physical, psychiatric and chemical disorders that may exist in any member, understand how these disorders, and the treatment of such, impact one another, and be able to provide case management care coordination with appropriate referrals. An understanding of the member's coping skills is vital to successful service planning.

When completing the Mental Health Assessment, it is important to demonstrate respect for the member living with a mental health issue. Assessor/case manager comments should be objective, descriptive, and without personal bias. Giving consideration to the member's comfort level, assessor/case manager's will want to continue to probe to obtain as much information as possible concerning the member's mental health. In addition, the assessor/case manager will need to document observation of the member's appearance, reactions, and behavior that may validate or conflict with the member's response.

Some questions in this section may have been answered previously in the interview. One way to build a positive working relationship with a member, and to demonstrate that you listened and care, is by being able to reiterate what you have already learned from the member. This empowers the member to feel more comfortable in sharing concerns and mental health disorder/symptoms. Frequently, the member's perception of you, the assessor/case manager, will impact on his/her desire/motivation to accept any referrals.

Safety first (which includes you, the assessor/case manager) is the **primary rule**. If a member is displaying increasingly erratic behavior, end the session and apologize for needing to leave. Call back in a day or two to reschedule the visit to finish the assessment as appropriate. **Be sure** the member recognizes/verbalizes awareness of who you are throughout the assessment, and responds to you appropriately as the assessor/case manager. You can judge this by his or her interactions with you.

During the assessment and member monitoring, it is very important for the assessor/case manager to be aware of any potentially life threatening behaviors. If life threatening behaviors are detected, the assessor/case manager needs to take appropriate and immediate actions to ensure the safety of the member and others who are in contact with the member. Assessor/ case manager's must be familiar with and follow agency guidelines when taking any actions, including contacting family, medical personnel, Adult Protective Services and/or law enforcement.

Life threatening behaviors include members with obvious signs/symptoms of suicidality, homicidality, or exhibit "a substantial risk of immediate serious physical injury to self, or immediate death, as manifested by evidence that the person is unable to provide for and is not providing for the basic physical needs of the person…" (excerpt from Title 43A Mental Health Law 1-103.18.e)

The following are *examples* of "risk of immediate serious **physical injury**"/inability to attend to one's own needs includes:
1. a member with paranoid ideations/delusions who is not eating due to belief the food is poisoned, exhibits marked weight loss and/or signs of malnutrition, there are dishes in the sink with mold on them, and the refrigerator has food with mold, indicating the person has not been eating for some time;

2. a member exhibiting signs of severe depression, the home is dark, he/she reports spending all of his/her time in bed, has not bathed, groomed nor changed clothing for some time, hair is matted/dirty, body odor noted, acetone breath is noted; reports not eating in days, either no desire or lacks the energy to get up to get something; again there are signs of marked weight loss (baggy clothes) and/or malnutrition.

3. a member exhibiting obvious signs/symptoms of mania, reports driving down the wrong side of the road recently, going out in the snow without proper clothing for warmth; has blisters on his/her bare feet from walking to a town 60 miles away for no known reason and calls a friend/family for a ride back home, or has not taken his/her medications (i.e. HTN, diabetic medication) due to their mania.

Some of the questions in the assessment are personal and may make the member feel uncomfortable. Assessor/case managers should be direct, polite, and sensitive to the member without becoming emotionally involved or upset. If necessary, the assessor/ case manager can pause to offer the member comfort, explain to the member why the questions are important and how they contribute to understanding his/her needs. Respect privacy if the member chooses not to answer or elaborate on prior treatment. Be sure to avoid unnecessary distress for the member, especially when inadequate coping skills or support system deficits are apparent. Note your concern and member's response. Follow-up can occur in subsequent visits by the case manager. Occasionally the opposite can occur with a member with anxiety or hypomania telling you his/her whole life story. Interject calmly, and try to redirect the member to the questions at hand. This may not be initially successful, and you may need to just listen, until the member has verbalized enough to be comfortable to move on.

Refer to Internet Web sites for information related to mental health issues and treatments such as the following sources: http://www.WebMD.com for information in layman terms and http://www.http/Medscape.com for information in more clinical terms.

1. Source of Information

Check the source of the information. If the source is someone other than the member, then check "other", and write the person's full name.

As with the MSQ and Self-Evaluation of Health, the Mental Health Assessment questions are answered by the member only. If other sources of information are present and contribute information, note the comments and the source in order to distinguish their information from the member's. If it is not possible for the member to respond, document the reason in the Comment box and go to #6.

2. Current Mental Health Problem

Indicate "no" in the appropriate space if the source knows that the member has no known mental health problems.

Indicate "yes" if any of the following applies:

The member has mental health problems, or has had them in the past. Obtain a specific diagnosis, such as schizophrenia or bipolar disorder, depression, anxiety or other mental health problems and describe history or other pertinent information on the line provided.

If the member exhibits behaviors that are a concern to assessor (or source), objectively describe the behaviors observed. Examples of such behavior include inappropriate speech or dress, confusion, wandering, withdrawal, repetitive speech patterns, paranoid statements, restlessness, clanging (use of words that pun or rhyme and only make sense to the member) , use of neologisms (use of words that only have meaning to the member), expressing delusional beliefs, responding to internal stimuli, etc. **Do not challenge a member's delusion, and do not enter it.** Remain calm and try to redirect the member to the assessment questions.

Service Plan implications: Mental health issues have a significant impact on a member's health and welfare. Depression is especially common and frequently under-treated. If a Member indicates a mental health need, then follow-up questions are required, like: "Have you felt this way before? What has helped in the past? Have you talked to your doctor about it? Do you think counseling might help? Answers to these types of questions may help identify needs and potential services that will need to be addressed by the Team during service planning. In addition, any knowledge the Case Manager may have about mental health resources in the community can be noted on the UCAT and explored by the Team.

3. Currently Receiving Services

Ask the member or source:

"Are you currently or have you previously received mental health services or counseling?"

Place a check next to the appropriate response. Circle "currently" or "previously" as indicated.

If the answer is "yes", ask the member from whom he/she received mental health services or counseling. Write the provider's name and, if possible, the address and phone number in the space provided, and write additional information (such as the reason for follow-up visits, names of medications taken, frequency of visits, and location) in the space provided for comments.

Clarify if mental health services or counseling are currently provided and with what frequency. If mental health services were provided in the past, indicate when and where services were received.

Service Plan implications: It is beneficial to explore a member's experience in mental health treatment. Is he/she willing to go back to a former provider? If not, why not? Knowing what options are available in the community enables the offer of a referral to another provider. Frequently member's are more receptive to home based counseling services covered by Medicare and/ or Medicaid, especially the elderly struggling with depression, with little or no prior treatment/counseling experience. Explore as to whether the Member felt the treatment experience is/was a positive/beneficial one. Is he/she willing to return if needed? Has he/she learned coping skills in addition to medication management of their symptoms?

4. Emotional Well-Being

Do not let your own personal discomfort with the following questions prevent you from asking them. It is not uncommon for some assessor/case managers, whether due mostly to personal discomfort, or lack of understanding of the purpose of these questions, to minimize the importance of the questions or just fill them in based on their own perception of how the member is doing. These questions open the door for discussion of mental health issues, signs, symptoms, and member safety, and help form the basis in service planning and care coordination. In not asking them, you do a disservice to our members. Practice asking one of your peers the same questions.

Tell the member:

"Now I have some questions about how you have been feeling during the past month."

Ask the member:

"In the past month, have you been satisfied with your life?"

If the member indicates "yes", then check the "yes" box and got to the next question.

If the member indicates "no", then check the "no" box and ask,

"Can you tell me what is making you feel this way?"

Quote the member and record the response in the Comments/Service Plan Implications box. Add observations as appropriate.

Ask the member

"In the past month, have you been feeling in good spirits?"

If the member indicates "yes", then check the "yes" box and go to the next question.

If the member indicates "no", then check the "no" box and ask the Member

"Can you tell me what is making you feel this way?"

Quote the member and record the response in the Comments/Service Plan Implications box. Add observations as appropriate.

Service Plan implications: Look for the member's sense of purpose. Member's may report triggers exacerbating symptoms of anxiety or depression. i.e. pain, lack of adequate income, loss of mobility, loss of loved ones, worsening health, etc. You may learn of something that is a motivator for the member to enter mental health services. Also, draw on what the member said his/her interests are to help form personal goals, that will motivate action/self help, (i.e. a member that is depressed and unable to physically leave the home, yet loves to crochet. Suggest he/she contact the nearest hospital or hospice to discuss donating crocheted caps for newborns or shawls for patients.)

Ask the member

"In the past month, have you been depressed or very unhappy?"

If the member indicates "no", then check the "no" box and go to the next question.

If the member indicates "yes", then check the "yes" box and ask the Member

"Can you tell me what is making you feel this way?"

Quote the member and record the response in the Comments/Service Plan Implications box. Add observations as appropriate.

Service Plan implications: Service planning may include education by a nurse or other trained professional on depression: causes, symptoms, treatments and coping skills.

Ask the member

"In the past month, have you been very anxious or nervous?"

If the member indicates "no", then check the "no" box and go to the next question.

If the member indicates "yes", then check the "yes" box and ask the member

"Can you tell me what is making you feel this way?"

Quote the member and record the response in the Comments/Service Plan Implications box. Add observations as appropriate.

Ask the member

"In the past month, have you had difficulty sleeping?"

If the member indicates "no", then check the "no" box and go to the next question.

If the member indicates "yes", then check the "yes" box and ask the member

"Do you know what might be the reason you aren't sleeping well?"

Service Plan implications: Service planning may include education by a nurse or other trained professional on anxiety and sleeping problems: causes, symptoms, treatments and coping skills. Example: Lessons on deep breathing exercises to help manage mild to moderate anxiety, avoidance of certain foods and drinks in the evening to promote healthy sleep habits.

Quote the member and record the response in the Comments/Service Plan Implications box. Add observations as appropriate.

Ask the member

"In the past month, have you seen or heard things that other people didn't see or hear?"

If the member indicates "no", then check the "no" box and go to the next question.

If the member indicates "yes", then check the "yes" box and try to determine if the member is in immediate danger of harming himself/herself or others with questions like:

"What you are seeing and hearing?" "How does this frighten you? " " Help me understand more about this." "Are the voices telling you to harm yourself or others?

"How long has this been happening to you?" "Has this ever happened before?"

"Does your doctor know?"

Service Plan implications: Contrary to popular belief, hallucinations do not always indicate a medical emergency. It is not uncommon for some people who have a mental health condition to manage hallucinations on a regular or intermittent basis. It is highly uncommon, however, for a person who has no history of a mental health disorder to experience hallucinations. Whatever the circumstances however, hallucinations always require further exploration.

First and foremost, the assessor/case manager needs to determine whether or not there is an immediate threat to the member or others. If the member or others are in imminent danger, the assessor/case manager must contact local authorities such as police and Adult Protective Services. Some communities have an emergency mental health team that can respond. It is important for the assessor/case manager to know the agency policies and procedures as well as what community resources are available.

If a member is not in immediate danger, the assessor/case manager can then begin to probe for additional information and determine whether or not the member may need formal and/or informal supports to be contacted. In assessing the cause and the impact of the hallucinations the assessor/case manager might ask a member who has a mental health conditions, "Are you taking your medications as prescribed? Have you talked to your doctor about the hallucinations? Do they interfere in any way with your everyday activities? Have you had to "learn to live" with them? Do the hallucinations frighten you? If the member has no history of a mental condition, the case manager may ask questions like: Have you recently started taking a new medication? Have you been sick lately? Have there been any major changes in your life recently? Have you been using any recreational substances? Have you been more short of breath than usual? Have you had any dizziness, slurred speech, numbness, or vision problems? Thorough assessment of hallucinations provides the Team (minimum of member, case manager, agency nurse) with essential information needed to determine the most appropriate referrals, monitoring schedule, and/or other interventions necessary to assure the health and welfare of the member.

Quote the member and record the response in the Comments/Service Plan Implications box. Add observations as appropriate.

Ask the member ***"In the past month, have you had thoughts about harming anyone?"***

If the member indicates "no", then check the "no" box and go to the next question

If the member indicates "yes", then check the "yes" box and try to determine if the member's thoughts indicate a serious threat or a possible mental health problem with questions like:

"Can you tell me more about this?" ***"Has someone harmed you or threatened you in any way?"***
"Have you thought about how you might harm someone?"

Quote the member and record the response in the Comments/Service Plan Implications box. Add observations as appropriate.

NOTE: If you conclude the member or others are in imminent danger, contact local authorities immediately and advise your supervisor in accordance with agency policy. Mandated reporters are required to notify APS / Local authorities immediately upon suspicion of maltreatment and that failure to do so could result in legal liability. Further, a mandated reporter is not obligated to prove out allegations of maltreatment, but rather only have suspicion to be mandated to report **.**

Ask the member, ***"In the past month, have you had thoughts about harming or killing yourself?"***

If the member indicates "no", then check the "no" box and go to the next question
If the member indicates "yes", then check the "yes" box and try to determine if the member's thoughts indicate a serious threat or a possible mental health problem with questions like: ***"Tell me more about these thoughts."*** ***"Do you have a plan?"***

Quote the member and record the response in the Comments/Service Plan Implications box. Add observations as appropriate.

NOTE: If you conclude the member or others are in imminent danger, contact local authorities immediately and advise your supervisor in accordance with agency policy. Mandated reporters are required to notify APS / Local authorities immediately upon suspicion of maltreatment and that failure to do so could result in legal liability. Further, a mandated reporter is not obligated to prove out allegations of maltreatment, but rather only have suspicion to be mandated to report **.**

It is crucial to ask - "Do you have a **plan**?" "How would you kill yourself?" Does the member have **access/resources** to carry out the plan? "Do you **intend** to carry this plan out?" "Have you done this before?" If a member relates having attempted suicide in the past, the risk is high he/she will try again. If a member verbalizes suicidal ideations, plan and intent, immediate intervention is needed.

A member may have thoughts such as wishing to end the pain (physical or mental as in incessant voices that are so loud and overwhelming), and have no intent to act on such because of their kids, spouse, having accepted it as part of their chronic mental illness, etc..

Ask the member, ***"Do you think anyone is plotting against you?"***

If the member indicates "no", then check the "no" box and go to the next question. If

the member indicates "yes", then check the "yes" box and try to determine if the member's thoughts indicate a serious threat or a possible mental health problem with questions like:

"Has a particular person or group made specific threats or tried to harm you?" "Can you tell me more about the threats?"

Quote the member and record the response in the Comments/Service Plan Implications box. Add observations as appropriate.

NOTE: If you conclude the member or others are in imminent danger, contact local authorities immediately and advise your supervisor in accordance with agency policy. Mandated reporters are required to notify APS / Local authorities immediately upon suspicion of maltreatment and that failure to do so could result in legal liability. Further, a mandated reporter is not obligated to prove out allegations of maltreatment, but rather only have suspicion to be mandated to report **.**

Service Plan implications: The emphasis in these questions is on serious, calculated thoughts of doing harm to oneself or others. Even when a Member's responses do not indicate an immediate danger, service planning may need to address underlying depression, disease processes, medication concerns, or other related issues that would trigger a need for referrals and/or increased monitoring.

In offering a referral, be aware that the Oklahoma Department on Mental Health and Substance Abuse Services has a "No Wrong Door" policy for all state funded/licensed Mental Health and Substance Abuse treatment facilities. Our Members may present with a complexity of needs - physical, psychiatric and chemical. Referring a member to the nearest mental health clinic, whether the issue is mental health and/or substance abuse, is an appropriate referral.

Be knowledgeable of what services occur in a mental health clinic. They have a psychiatrist, nurse to dispense medications/injections, therapist to provide counseling services, and case managers to assist members in accessing medical services, finding a place to live, teach homemaking skills (rehabilitation), accompany to court proceedings, etc. There are also PACT (Program of Assertive Community Treatment) services in several counties across the state that provide mental health services to members in their home. They too have a psychiatrist, nurse, therapist and case managers to provide the services in the home, and assist members with attending medical appointments. Coordination of care between the Advantage case manager and metal health service providers is crucial. Take the time to call and introduce yourself, visit a clinic and PACT program to be knowledgeable of staff names as well as their services. Being able to give a contact name and state you've met the person eases a member's anxiety.

Progression and relapse are part of both alcoholism, drug addiction, and various forms of mental health disorders, as well as most chronic physical health conditions. With addiction and mental health, the very nature of the illness can prevent an individual from being able to self identify their diagnoses/disorders. It is not uncommon for an individual to feel good and stop medication/treatment, mistakenly believing that healing has occurred and life can be managed without the medication/treatment. This behavior frequently occurs with antihypertensive medications, diabetes medications, antibiotics, etc, and should come as no surprise with mental illness. Service planning to include continued monitoring and education on disorders, pointing out symptoms as they occur, may help motivate a return to medication therapies, treatment clinics or home based services.

Be sure to include the member in, and gain permission for, all mental health service planning.

5. Memory Assessment

Tell the member

"I'd like to ask you some questions about your memory and your ability to find things."

If the member asks "why", explain this will help determine what services he/she might need.

Ask the member

"In the past month, have you had problems with your memory?"

If the member indicates "no", then check the "no" box and go to question F5b.

If the member indicates "yes", then check the "yes" box and ask:

"What kind of problems have you had?"

Quote the member and record the response in the Comments/Service Plan Implications box. Add observations as appropriate.

Ask the member

"In the past month, have you frequently lost items such as your purse/wallet or glasses?" If

the member indicates "no", then check the "no" box and go to question F5c.

If the member indicates "yes", then check the "yes" box and ask:

"How often would you say that has happened?"

Quote the member and record the response in the Comments/Service Plan Implications box. Add observations as appropriate.

Service Plan implications: The assessor/case manager will want to distinguish between the common forgetfulness that most people experience and dementia. The member's response could validate or conflict with the MSQ and Health Assessment sections. Documentation regarding members who wander and/or have significant memory disorders needs to clearly state how those situations are being managed. These may be emergency situations depending upon the amount of impairment and/or support currently available. Service plan implications typically include physician and/or psychiatric referrals, supervision needs, availability of informal supports, and increased monitoring.

Ask the member

"In the past month, have you had trouble recognizing family members or friends?"

If the member indicates "no", then check the "no" box and go to the next question.
If the member indicates "yes", then check the "yes" box and ask:

"About how often would you say that happens?"

Quote the member and record the response in the Comments/Service Plan Implications box. Add observations as appropriate.

Ask the member

"In the past month, have you lost your way around the house; for example, couldn't find your bedroom or the bathroom?"

If the member indicates "no", then check the "no" box and go to the next question.
If the member indicates "yes", then check the "yes" box and ask:

"How often would you say that has happened?"

Quote the member and record the response in the Comments/Service Plan Implications box. Add observations as appropriate.

Ask the member

"In the past month, have you forgotten to turn off the stove?"

If the member indicates "no", then check the "no" box and go to question #6 & #7.
If the member indicates "yes", then check the "yes" box and ask:

"How often would you say that has happened?"

Quote the member and record the response in the Comments/Service Plan Implications box. Add observations as appropriate.

6. In your judgment, does the member...

This is answered by the assessor/case manager only.

For these questions, use the checklist of problems to summarize your conclusions from the mental health assessment, indicating your response by checking under the "yes" or "no" column as appropriate. All "yes" responses require a comment. If "yes" is checked for supervision required, be specific about why and when supervision is needed.

7. Does the member require:

This is answered by the assessor/case manager only.

For this question use your judgment based upon your observation and the responses given in this section.

Place a check mark in the appropriate space to indicate the member's needs:

Immediate intervention

Mental health referral

Neither

IMMEDIATE INTERVENTION NEEDED

Throughout the Mental Health Section, the possible need for immediate intervention has been addressed. Review positive (yes) responses to the following questions which may require an immediate intervention:

In the past month, have you seen or heard things other people didn't see or hear?

Had serious thoughts about harming anyone?

Had serious thoughts about harming or killing yourself?

Is someone plotting against you?

Follow policies and procedures for handling emergency procedures as addressed in your agency.

MENTAL HEALTH REFERRAL

A mental health referral is a referral for routine mental health assessment and consideration for services by a mental health provider.

In addition, a referral for mental health concerns may be made to the primary care physician, support groups, and/or community agencies and organizations. Once mental health concerns are identified, it is critical that those issues are followed in the most appropriate setting.

Example

If the family needs information, they should be referred to groups such as the Alzheimer's Disease Association, local mental health agencies, or other local support groups. Possibilities exist within most communities to assist with ongoing counseling or information.

NEITHER

In some circumstances neither a mental health assessment nor referral is necessary.

Example

There are no mental health responses of concern

The concerns identified are currently well managed

Place a check mark in the appropriate space to indicate when a member needs (1) immediate intervention (2) mental health referral or (3) neither.

In the Box to the right of the choices marked, document why or who if immediate intervention and any action needs to be taken. This information is needed for both "immediate intervention needed" and "mental health referral".

Refer to Oklahoma Department on Mental Health and Substance Abuse Services website http://www.ok.gov/odmhsas **for current information related to mental health, substance abuse, prevention programs, services and information, referrals, etc..**

There are two items and a clinical judgment to be completed in this section.

1. Subjective Evaluation of Environment
2. Safety and Accessibility

Introduction

The purpose of the Environmental Assessment is to evaluate the member's physical environment for safety and accessibility. The assessor/case manager assigns an environmental clinical judgment score based on information collected by the assessment. The information is compared to established criteria and corresponding scores for no risk, low risk, medium risk, and high risk. Once a risk level is determined, the assessor/case manager documents how a member meets the criteria for the risk level chosen.

To complete the assessment, the assessor/case manager uses questions and direct observation. It is important for the assessor/case manager to remain objective. Acceptable standards of living may be defined very differently by different people. The assessor/case manager will want to see areas of the home used by the member and note safety and/or accessibility concerns. Always ask the member for permission before checking any room in his/her home. If possible, ask the member to accompany you. Having the member involved helps allay fears a member may have about the assessor/ case manager's intentions (being nosey, prying into the member's personal space, etc.). It also gives the assessor/case manager more opportunities to observe the member's functional and mobility skills.

1. Subjective Evaluation of Environment

Ask the member

"Are you concerned or afraid for your safety in your home or your neighborhood?"

If the member indicates "no", record "no" box and go to the next item.

If the member indicates "yes", record "yes" and ask:

"Can you tell me more about your concerns?"

Document the member's response. This question is to be directed to the Member. Ask additional probing questions as necessary to determine possible criminal activity in the neighborhood and/or physical hazards.

2. Safety and Accessibility

In order to evaluate safety and accessibility, you must observe the member's environment and indicate the specific area(s) in which actual or potential safety or accessibility problems for the member exist by placing a check next to the relevant item. Make notes for service planning under Problem Area.

In the space for comments provide specifics about the problems and areas in need of attention. Indicate the immediacy of the need (danger/threat to the member's well being). State any concerns voiced by the member, or concerns of your own, and ways that these may be addressed. Document all safety and accessibility concerns.

Service Plan implications: Some programs provide environmental modifications as a service. Only adaptations that are necessary to ensure health, welfare and safety of the member, or which enable the member to function with greater independence within the home and without which, the member would require institutionalization are approved. Adaptations or improvement to the home which are not of direct medical or remedial benefit to the waiver member are excluded. Although some Programs provide limited environmental modifications, you will want to first explore community resources for these services. When homes are owned by someone other than the member, the landlord should always be approached first about providing modifications and repairs. Government subsidized housing requires the homeowner make repairs. Most communities have resources for environmental modifications, home repairs, heating and air, telephone service, pest control, etc. Many companies will donate the service, charge a reduced fee, or allow a payment plan. Community reorganizations, church groups, family members, and neighborhood volunteers may also be available. Often, local fire departments provide free smoke alarms. Partner provider agencies should have information on community resources in their area to assist the assessor/case manager in locating these services. When safety concerns are so serious as to threaten the member's ability to stay in the home, the assessor/case manager helps the member explore all the options and information needed to make an informed decision. A plan for temporary housing may be appropriate if there are resources to restore the home. Be sensitive to the member's emotional ties to his/her home. Ask questions like, "Do you like living here? What is most important to you about living here? If you had to move, what kind of place would help you feel safe and comfortable? Is it important that you live in the country, the city, near your church, near your family? Would you want to take your pets?" Also, keep in mind, as long as a member has mental capacity and the property has not been condemned by the authorities, the member has the right to live where he/she chooses. If it is unsafe to send workers into the home, the assessor/case manager will want to explain, in a non-threatening way, how the member's choice will affect his/her ability to receive services. If a member chooses to remain in an unsafe environment, the assessor/case manager might consider continuing Case Management services to monitor the member's status. Adult Protective Service involvement may be needed.

Structural Damage, Dangerous Floors

Observations

Exposed wiring

Creaking or uneven floors

Ceilings with water marks

Doors that open with difficulty

Windows that cannot be opened

Outside structure that looks crooked

Questions

How old is your house?

Have you consulted anyone about (problems from observation list)?

Barriers to Access, including steps and stairs

Observations

Member lives above first floor

Member lives in building with no elevator and has limited or deteriorating mobility

Member lives in two story home and bedrooms are upstairs

Member cannot climb stairs

Member is in wheelchair and entrance to home has steps

Doorways too narrow and rooms too small to maneuver

Questions

Does someone help you to leave your apartment?

Are you able to go upstairs?

If the member uses a wheelchair, ask how he/she accomplishes certain tasks. This includes leaving home, cooking, using bathroom, reaching up in cabinet or freezer, getting mail, etc.

Electrical Hazards

Observations

Frayed electrical cords

Over-use of extension cords

Plugs partially hanging out of wall

Poor wiring in the home

Flickering lights

Questions

Have you ever been shocked when you tried to unplug anything?

Do you have to change fuses frequently?

Has your electric bill increased even though you're not using more appliances, etc?

Fire Hazards/Safety Equipment

Observations

Electrical hazards

Wall-to-wall clutter

Member smokes and appears to be careless (burns, etc.)

No smoke alarms

Un-vented space heater in use

Use of cooking stove as a heat source

Questions

Have you ever fallen asleep while smoking?

Do you forget things on the stove or in the oven?

Do you have a fire extinguisher? Do you know how to use it?

When was the last time you checked the smoke alarm and changed the batteries?

Do you have a timer to set when using the oven or toaster oven?

Unsanitary Conditions/Odors that Affect Health, Safety, or Ability to Receive Needed Care

Observations

An obvious odor in the house

A dirty house- trash in places other than receptacle, or, overflowing; pet wastes and odors

Wall-to-wall clutter

Dirty and odorous bathroom Soiled

carpet and/or furniture

Questions

How old is your house?

Have you consulted anyone about (problems from observation list)?

Insects or Other Pests

Observations

Pests or pest droppings

Odor of dead rodents

Questions

Do you have a pest control service?

Do you have roaches, rats, or mice in your home?

Do you have bug spray or roach tablets?

Poor Lighting

Observations

House is dark or shadowy even with the lights on (some people keep the house closed and dark to keep it cooler during the warm months)

Covers of light fixtures are dusty and/or dirty

Questions

Is the light sufficient for your needs?

Insufficient Hot Water/Water

Observations

Excessive amounts of dirty dishes from lack of water

Poor hygiene because of lack of water

Member is wearing dirty clothes because of lack of water

Bathtub and sinks soiled and appear unused

Questions

Do you have running water?

Do you have hot water?

Insufficient Heat/Air Conditioning

Observations

Temperature too hot or cold inside the Member's home

Room is stuffy during the summer months (Some people have air conditioning but do not use it in order to keep electric bills low.)

Cold or hot breeze felt near closed windows and doors

Questions

How do you keep warm in the winter?

Do you have central air/heat, and how well does it work?

Do you have to unplug another appliance to run your space heater or air conditioning?

Do you sleep with a space heater on at night? (This is a possible fire hazard)

Does the heat bother you in the warm months?

Do you run your air conditioner during the warm months?" If the answer is no, then ask, "Why do you not run your air conditioner?

If you are unable to afford to run the air conditioner, have you spoken to the utility company about a budget plan?

Do you use fans?

Shopping Not Accessible

Observations

No food in cabinets/pantry

Prescriptions not filled

Questions

How do you do your shopping?

When was the last time you went to a grocery store?

Can you afford to pay someone to shop, pick up prescriptions, etc?

Transportation Not Accessible

Observations

Member unable to get to local transportation pickup

Member does not drive or have anyone who can drive him/her

Questions

Do you drive?

How do you shop or run errands?

Do you know of any community agencies that provide transportation for medical and shopping needs?

Are you able to get on a bus (able to climb the steps, etc.)?

Telephone Not Accessible

Observations

No phone in sight

No phone number listed on referral

Questions

Are you able to afford a phone?

How would you get help in an emergency

Are you able to use a neighbor's or friend's phone?

How can I reach you if I need to contact you?

Neighborhood Unsafe

Observations

Evidence of criminal activity and physical disorder

Questions

Do you feel safe inside your home?

Have you ever had to call '911' for any reason?

Has your home ever been broken into?

Member Unable to Evacuate in Emergency

Observations

Doors, windows boarded up

Doors are locked from the outside or with a key the member does not have access to, stairs are present, etc. making it impossible for the member to evacuate in an emergency

Obstructed access to an exit from the building

Member's bedroom has less than two means of exit (unobstructed window/ door)

Questions

Do you think you are able to evacuate safely in an emergency? How?

What would you do if there was a tornado or another emergency (fire, flood, etc.) ?

Problem area: Document comments related to any potential safety or accessibility items checked above.

The Environmental Assessment Score is based upon your judgment of the member's physical environment. The information is compared to established criteria and corresponding scores for **no** risk, **low** risk, **moderate** risk and **high** risk. Use the following descriptions as a guide for selecting the appropriate risk level. Include justification for the level indicated. Remember you may not have the same tastes or ideas of what is 'clean' or 'cluttered' as the member. Your judgment should concern only items/situations that may threaten the member's ability to live safely in the environment.

Transfers and mobility are addressed in ADLs. You are scoring physical barriers in this section

Scoring Environmental Risk

Category	Score	Description
No Risk	0	**The physical environment is generally well equipped and supportive**. This includes home, building, neighborhood, and necessary furnishings.
Low Risk	5	**The physical environment has a few negative aspects**. The few negative aspects are minor or within acceptable living standards and are not hazardous to the member's well-being.
Moderate Risk	15	**The physical environment is negative**. Many aspects are substandard or hazardous. The member may not be able to remain in the current dwelling.
High Risk	25	**The physical environment is strongly negative or hazardous**. The member should change dwellings or is very likely to need to change dwellings unless immediate corrective action is taken to address.

Level of care implications: Accurate and precise information indicating an Environmental Risk Clinical Judgment is used by OKDHS and OHCA in determining level of care needs of members. It is vital this information is clear and agrees with the remaining documentation within the UCAT to assure the member is given services in the most appropriate service program.

Landlord/Yard or Home Repair

Enter the name and phone number of the Landlord if applicable. Enter the name and phone number of persons responsible for yard work/ home repairs as applicable.

Service Plan implications: Accurate information in this section is important if DME requiring installation or home modification is needed. Signed documentation of the home owner giving permission to make installation or modification must be obtained prior to any modifications/installations..

Caregiver Assessment Information

There are twelve items to be completed in this section.

1. Primary Caregiver
2. Length of Caregiving
3. Frequency of Caregiving
4. Type of Help Given
5. Caregiver Employment
6. Alternate Caregiver 7.

Caregiver's Health

8. Caregiver's Well Being
9. Caregiver's Difficulties in Managing Care
10. Caregiver's Training/Services
11. Caregiver's Problems
12. Continuity of Care

Introduction

The intent of this section is to assess the primary informal caregiver's response to care giving and to determine his/her capacity to continue. The primary informal caregiver is any individual, usually family or a friend, who provides care and support on a regular basis and who does not get paid for their services. If there are multiple informal caregivers, include names of all assistants but determine the "lead caregiver" and interview that individual as primary.

The assessment questions are directed to the caregiver. The assessor/case manager may choose to conduct the caregiver assessment at the time of the initial interview or at a later date. If the caregiver is not available for a face-to-face interview, the assessment can be completed by telephone. Much of the information may have already been obtained from the Functional Assessment and the member Supports Assessment. When this is the case, the assessor/case manager can simply verify the accuracy of that information and transfer it to the Caregiver Assessment to avoid redundant questioning.

1. Primary Caregiver

This question is answered by the assessor/case manager.

If the member does not have a primary informal caregiver, then record "No". Record any concerns in the Comment Box if applicable, and go to the next section.

If the member has a primary informal caregiver, then record "Yes" and record the caregiver's name, relationship to the member, address, and phone number in the spaces provided.

Service Plan implications: Limited informal support can place the member at risk of institutionalization, especially in the event of an injury or advancing disease process. When a member indicates he/she has no or limited informal resources, then the Team will need to work closely with the member to develop those supports, if possible. The assessor/case manager can help the member explore supports such as those identified in the Social Resources Assessment, friends, neighbors, volunteers, and community and agency organizations. Although certain requirements must be met, it is possible that a member's primary informal supports are hired to provide caregiver services formally. Be sure to clearly document when paid caregivers originated as informal supports (friends and family). In this situation, the service plan will need to reflect which services will be provided by the Caregiver informally, and which services the Caregiver will perform as a paid provider. When the primary informal Caregiver is also acting as the paid provider, it is likely the assessor/case manager will need to increase monitoring to assure the arrangement is stable. It is also important to have a "back up " plan in place to ensure the member's needs are met when both informal and formal supports are unavailable.

2. Length of Caregiving

Ask the caregiver:

"How long have you assisted the member?"

Record the caregiver's response in the spaces for the number of years and months.

3. Duration of Caregiving

Ask the caregiver:

"How often do you assist the member?"

Read the list of possible responses to the caregiver, and allow him/her to choose the most appropriate item.

Possible answers are:

every day
several times a week at least once a week
less than once a week
never
don't know

4. Type of Assistance Given

If the caregiver is the source of information in other sections, use that information here to avoid redundant questioning. Then go to the next item.

If the member or another source provided information for other sections, ask the caregiver:

"What kind of assistance do you give the member?"

Record the responses for each assistance category, and use the comment space on the form to record any issues that have service plan implications for the caregiver or the member.

Use the following examples of activities in each category when asking questions:

Personal care. Includes assistance with bathing, dressing, toileting, shampooing hair, feeding, changing bed linen, transferring, assistance with mobility and supervision of medication.

Housekeeping. Includes assistance with meal preparation, laundry, clothing repair, dishes, sweeping, vacuuming, mopping, and dusting.

Transportation. Includes transporting member for medical appointments, shopping, recreational/educational activities, visiting family/friends, and making arrangements for the member's transportation needs.

Shopping and errands. Includes shopping for food, medicines, clothing, and personal items, and running errands to pay bills or taking care of the member's personal business.

Supervision for the safety of the member. Includes activities such as 24-hour care of the member, day-time care, locking doors, supervision of bathing, medications, nutrition, and supervision when the member is using the stove or oven, assistance to the member in climbing stairs, and companionship in unsafe neighborhoods.

Money management assistance. Examples of assistance include check writing, making bank transactions, paying bills, investigating possible billing errors, and making investments.

Other (specify). Ask the caregiver if he/she provides other assistance. Examples include job coach, employer and immediate supervisor who assists in carrying out the tasks of employment, home repair, letter writing, reading to the member, heavy cleaning, yard work, companionship, and making phone calls.

5. Caregiver Employment

Ask the caregiver:

"Are you employed full time, part time, or not working at all?"

Record the caregiver's response.

6. Alternate Caregiver

Ask the caregiver:

"If you were suddenly unable to provide care who would take your place?"

If the caregiver states "nobody," check the appropriate space.

If the caregiver provides the name of another person, record the name and relationship to the member of that person.

assessor/case managers may want to probe further about the nature of the alternate care giving by asking the caregiver:

Would the assistance be temporary or permanent?

Would the person be able to provide the same type and amount of assistance?

Record the caregiver's response on the line provided.

7. Caregiver's Evaluation of Health

Ask the caregiver:

"How is your own health? Would you say it is excellent, good, fair, or poor?"

Record the appropriate response.

Do not make a selection for the caregiver. This is the caregiver's subjective evaluation of his/her health and can be answered only by the caregiver.

CAUTION—The caregiver's answer to this question may be a predictor of his/her potential for continuing or not continuing to provide care.

8. Effects of Caregiving on Caregiver's Well Being

These questions concern the relationship the caregiver has with the member and how it affects (positive or negative) other areas of the caregiver's life. It is important to determine whether there is or will be a problem and whether the caregiver feels overburdened.

Tell the caregiver:

"Considering the assistance you provide (the member), I would like to ask you whether various aspects of your life have become better, stayed the same, or become worse since you began providing care."

Ask the caregiver:

"Has your relationship with (the member) gotten better, stayed the same, or gotten worse?"

Record the caregiver's response.

Continue asking the questions for this section. Ask

the caregiver to explain his/her responses.

Record pertinent information in the Comments box.

9. Caregiver's Difficulties in Managing Care

Ask the caregiver:

"Is there anything else we need to know that makes it difficult for you to manage care?"

Record the caregiver's response.

If the caregiver's response was yes, then describe in the space provided any additional difficulties he/she has in providing care.

To further determine how the caregiver is handling the caregiving responsibilities, you may wish to probe to determine how he/she responds to specific behaviors about the member that have been identified.

Examples of member behavior that may be disturbing to a caregiver are:

Forgetting things
Wandering or getting lost
Being suspicious or accusative
Reliving situations from the past
Lacking control of bowel or bladder
Being unable or unwilling to feed self
Being unable or unwilling to dress self
Being unable or unwilling to clean house
Being unable or unwilling to prepare meals
Being unable or unwilling to bathe or shower
Negativity

Service Plan implications: When a Caregiver is experiencing difficulties providing care there are numerous service plan implications to consider such as "Can training or services alleviate the burden? Is there potential for abuse or neglect? Is increased monitoring by the assessor/case manager and/or the Skilled Nurse needed to assure the member's health and welfare? Is there a back-up plan? Are there other informal supports available?" Studies have shown that incontinence and wandering contribute highly to Caregiver burnout. Is the care/ support continuous without relief? Does the caregiver have conflicting responsibilities such as job and/or child care? Is the care being provided by persons with advanced age and/or disability". A plan that includes regular strategies to shore up the needs of the caregiver is more likely to succeed long term. The Team will want to pay particular attention to these issues.

10. Caregiver Training/Services

Ask the caregiver:

"Do you need training or services?"

Check the appropriate space.

If the caregiver's answer is "yes" provide a description of the training or service needed.

Examples of training that a caregiver may need:

Body mechanics
How to dress and groom the member
How to provide nutritious meals and assist the member at mealtime
How to check the status of the member's health How
to provide exercise and activity assistance
Help with bowel and bladder care, training programs or devices
Help in dealing with communication and sensory loss

Examples of services a caregiver may need:

Respite to allow the caregiver to attend to other obligations outside the home
Caregiver support group
Newsletters addressing member's diagnosis
Financial aid

11. Caregiver Problems

This question is answered by the assessor/case manager.

If the Caregiver has reported multiple problems that may threaten his/her ability to continue with caregiving, then check the "very much a problem" box. If the Caregiver has reported only a few problems, check the "somewhat a problem" box. If the Caregiver has reported no problems, then check the "not at all a problem" box.

Service Plan implications: A Caregiver who is managing responsibilities with little or no detrimental effects on other aspects of his/her life or the relationship with the member is likely to continue to provide support. In situations where care giving becomes burdensome, the quality of care can decline and/or the relationship with the member can deteriorate. The Team must constantly evaluate the stability of support systems and amend the plan as needed. Careful monitoring is key as even the best situations can quickly change and threaten the member's health and welfare.

12. Continuity of Caregiving

This question is answered by the assessor/case manager.

If it is likely the Caregiver will continue to provide care to the member, then check the "very likely" box.

If there is some doubt the Caregiver will continue to provide care, then check the "somewhat likely" box.

If it is most probable the Caregiver will not continue to provide care, then check the "unlikely" box.

Comments on Caregiver/Service Plan implications

Indicate any conditions that may be detrimental to the caregiver's ability to continue a high quality level of care.

Service Plan implications: Caregiver relief can be approached in many different ways. Soliciting help from family, friends, and community resources may be possible. It might be appropriate to coordinate formal personal care service to alleviate some of the Caregiver pressure. Formal respite care and Adult Day Health may also be options.

13. Member Support Score (Consumer Support Clinical Judgment)

Introduction

The assessor/case manager assigns a Member Support Risk score based on information collected from the Functional Assessment , the Member Supports and Social Resources Assessments, the Mental Health Assessment, and the Caregiver Assessment. (Remember, spouses, parents and other adults who do not have disabilities and who live in the same household are expected to take responsibility for general household maintenance tasks.) The information is compared to established criteria and corresponding scores for very low, low, moderate, and high risk. Once a risk level is determined, the assessor/case manager is required to document how a member meets the criteria for the risk level chosen.

The intent of the Member Support Clinical Judgment is to rate the level of risk posed by the member's need for informal and formal services. On initial assessments, the assessor may find dedicated family supports and rate the member as low risk. The task, however, is to analyze if there are service needs beyond what the current informal and formal resources can provide AND whether or not current supports are stable. If current supports are inadequate or fragile (meaning they cannot continue at the current level), and additional services are needed, the risk is at least moderate.

Similarly, when administering a reassessment, an assessor/case manager may mistakenly score a member's risk as low because services are in place and stable. The member's needs, however, may not have changed at all, indicating the assessor/case manager has rated the effectiveness of the services instead of the member's need for them. With reassessments, the assessor/case manager needs to ask, "If State Plan or waiver services were not in place, would the member's need be met?" If the answer is "no", the risk level is at least moderate. If the answer is "yes", then the Team may need to re-evaluate program appropriateness.

Documentation

The information is compared to established criteria and corresponding scores for very low, low, moderate, and high risk. Once a risk level is determined, the assessor/case manager is required to document how the member meets the criteria for the risk level chosen. The risk level must be supported by the information obtained in the assessment. Clearly document the clinical decision indicating with **specific personal information related to the member's** sufficiency/stability of support system, unmet needs, availability/ability/willingness of informal caregivers to meet needs, community potential and risk of nursing home admission as to ***why*** the risk level was chosen. Use the grid on the following page as a guide by checking one box in each column that best identifies the member's current situation. The overall Member (Consumer) Support Clinical Judgment risk level and score is determined by the risk level with the preponderance of checks.

Level of care and Service Plan implications: Each member's support dynamics are unique and require thoughtful analysis. Cultural beliefs can influence who is and is not allowed to assist a member. Gender difference might be a barrier. In some cultures, there are designated family members responsible for caregiving. A service plan that balances informal support with formal supports and is compatible with a member's cultural values will be the most effective plan. Accurate and precise information indicating a Consumer Support Clinical Judgment is used by OKDHS and OHCA in determining level of care needs of members. It is vital this information is clear and agrees with the remaining documentation within the UCAT to assure the member is given services in the most appropriate service program.

To determine CONSUMER SUPPORT CLINICAL JUDGMENT check one box in each column beginning with Sufficiency/Stability of Support System. The overall Risk Level and score is determined by the preponderance of checks.

RISK LEVEL	SCORE STABILITY	SUFFICIENCY/ ITY/WILLINGNESS OF SUPPORT SYSTEM	UNMET NEEDS OF	AVAILABILITY/ ABIL- NITY PO- INFORMAL CAREGIV- ERS TO MEET NEEDS	COMMU- NURSING TENTIAL	RISK OF HOME ADMIS- SION
Very Low	0	**Sufficient/ Stable**	**None**	Member/Family/ Informal supports are **sufficient** for present level of need in **most** functional areas	**High**	**No risk**
Low	5	**Nearly Sufficient/ Stable.**	**Minimal or few** needs for formal services (i.e. some housekeeping only)	Member/Family/ Informal supports are**nearly sufficient** for present level of member need in most functional areas. Needs are those that are typically expected for family/ household members to share or do for one another, i.e. general household maintenance	**High**	**Little risk** even with loss of current supports
Moder- ate	15	**Inadequate, Changing, Fragile, Problematic** (i.e. lack of caregiver continuity, caregiver burnout; conflicting responsibilities of the caregiver such as job and child care; advanced age &/or disability of caregiver). Back-up Plan is likely to fail without formal assistance	**Multiple** needs that may or may not include the need for additional assistance with personal care	Member/Family/ Informal supports are **meeting some** of needs. Needs usually include intimate personal care tasks that individuals normally do for themselves	**Moderate**	**Reasonably expected** with any major change in current support system (i.e., loss of ADvantage or State Plan services; decline in caregiver supports)
High	25	**Entirely inadequate** to meet high degree of client need. Stability of care system is likely to fail	**Multiple** medically complex needs that include personal care. Functional capacity is so limited as to require full time assistance	Member/Family/Informal supports are **meeting few or none** of the needs	**Low**	**Very likely** even with supports currently in place

RECOMMENDATIONS

There are six areas to be completed in this section.

1. Scoring Matrix
2. Overall risk score
3. Alternatives Discussed
4. Recommendations
5. member's Needs/member's Choice/Family/Caregiver's Choice/Assessor's Recommendations
6. Signature of Assessor

Introduction

In this section the assessor/case manager compiles all of the scores from the UCAT III to determine an overall risk score, indicates alternatives discussed with the member, and makes a recommendation regarding the member's community potential.

The Recommendations section is not completed in the member's home. The assessor/case manager will want to review the member's UCAT, check medical records, if available, and make follow-up phone calls or visits if needed, to gather any additional information required before completing this page. Assessor/case managers will also need to be aware of the member's and the family/ Caregiver's choice of settings.

Scoring Matrix

The Scoring Matrix is a table for collecting/capturing the numbers obtained during the scoring of each domain of the UCAT. It is the opportunity to collect all of the scores and place those numbers in table format. The columns of numbers in the table are then added together to produce a total UCAT score. **If using the ELDERS format, it will automatically complete the matrix and add the scores.**

Total Score/Overall Risk

Add the numbers in each score column. Place the sum in the sub-total columns and place the combined score in the box marked Total Score. Check the appropriate Overall Risk Score Range based on the range the Total Score falls within. **If using the ELDERS format, it will automatically complete the matrix and add the scores.**

Homebound Status

Answer 'yes' or 'no' to the need for the assistance of another person in order to leave the home. This status is also noted within the UCAT Part I.

Referrals

Answer 'yes' or 'no' to the need for further physical or mental health assessment/ services.

Assessor Override

Answer 'yes' or 'no' to the use of assessor override of any of the domain scores. Assessor overrides should be used rarely and with caution to avoid undermining the scoring system that is incorporated into the UCAT. You may override the score derived from the form if extraordinary circumstances exist that are not evidenced by the assessment scoring. All assessor overrides require a **written justification** within the UCAT and **supervisor approval**.

Expanded Criteria

Some programs allow for a recommendation of medical eligibility due to expanded criteria. Refer to current Oklahoma Administrative Code for the specific criteria requirements prior to responding to this question/box.

Alternatives Discussed

Place a check next to each of the alternatives that you discussed with the member and caregiver during, or subsequent to, the assessment. List any information or literature you left with the member.

Recommendations

From the list of alternatives, select the letter(s) that represents the alternative which best describes your recommendation for the member. Example: If you recommend that the member seek placement in an RCF with additional services, then place the letter ***"c"*** in the blank.

Member's Choice- Indicate the member's choice(s) for care as expressed by the member by selecting the appropriate code from the alternatives above. Example: If the member's preference is to remain home with services, then place the letter **"a"** in the blank.

Family/Caregiver's Choice- Indicate the family/caregiver's choice(s) for the member's care by selecting the appropriate code from the alternatives above. Example: If the family or caregiver is undecided about a choice for the member, but would like short-term respite care, then place the letters **"n"** and **"g"** in the blank.

Signature of Assessor(s)

The person completing the assessment must sign, date, and list his/her current employing agency. **ELDERs provides an electronic signature of the assessor.**

APPENDIX

Tips on Developing Rapport During an Interview

Prior to beginning the UCAT interview, assessor/case managers will want to take time to establish rapport with the member and/or caregiver. Developing rapport will make the member feel more comfortable. Valuable information will be gathered more readily, resulting in a better understanding of the member. Knowledge of the member will help facilitate the conversation and prompt additional questions.

Obtaining and maintaining a productive relationship with a member requires building rapport from the beginning of the relationship. The following tips are designed to assist assessor/case managers in developing rapport during the UCAT interview:

Speak in a conversational tone.

Give the member choices when possible, such as 'where would you like me to sit?'

Spend time talking about something other than the assessment (small talk).

Before starting the assessment, tell the member you will be asking questions about his/her health, strengths and challenges, personal habits, supports within the home and community as well as home environment. Explain that the purpose of the visit and assessment is to identify current/existing needs so these can be addressed within the appropriate program (eligibility) during service planning. Explain that the assessment typically takes two to two and a half hours to complete. Tell the member that another visit can be scheduled if he/she becomes too fatigued to complete the entire assessment in one setting.

Give the member a brief overview before starting each section.

Encourage the member to ask questions.

Listen to the member and make a mental note of speech patterns. This will help you pace the assessment to the characteristics of the member.

Always remain professional, but don't be afraid to enjoy yourself. If you are relaxed, then the member can relax.

Frailty in the Aging Population

There are numerous predictors (high risk) of poor health and safety outcomes in the elderly and disabled population. Some predictors are specific and easily identified by non-clinical review of the individual's UCAT. These include the presence of a very high MSQ without 24 hour supervision, necessity of a Ventilator for breathing, APS involvement, etc.. In addition to these indicators, there are risk factors that point toward the risk of death, hospitalization or a rapid decline in health and safety that require an advanced clinical review (critical thinking process) to both discover and evaluate if service plan interventions are adequate to mitigate the risks. Critical thinking allows recognition that the plan of care for a ninety year old with chronic illness in all likelihood will and should differ from that of a seventy five year old with the same illness.

Frailty (also includes 'the dwindles' or failure to thrive) in the elderly increases susceptibility to acute illness, falls, disability, social isolation, institutionalization and death. Frailty is defined as 'a physiologic syndrome characterized by decreased reserve and resistance to stressors, resulting from cumulative decline across multiple physiologic systems, and causing vulnerability to adverse outcomes.' (Fried et al. 2003). No one diagnosis or set of circumstances lead to frailty, however, multiple interacting disease processes give clue that frailty is likely. Frailty frequently presents with weakness/fatigue and exhaustion, weight loss and malnutrition, falls, immobility, low exercise tolerance, low energy expenditures, poor hand grip, slow walking speed, incontinence, cognition and mood changes, 'giving up' and social crisis. Predictors of frailty include extreme age, visual loss, impaired cognition/mood, limb weakness, abnormalities of gait and balance, sedative use and multiple chronic diseases. Frailty often results in and leads to a spiraling decline in health, a vulnerability to and reduced recovery from acute illness, an increased likelihood of further decline and increased mortality.

Recognition and early intervention is key. Incorporating strategies into the service plan can prevent, reduce and reverse frailty. **Small changes can result in major functional gains!**

- Educate Individual and family on proactive ways to reduce risks associated with frailty.
- Seek medical treatment (geriatric assessment) early for pain, acute illness, functional decline, medication compliance and cognitive impairment due to delirium, depression and dementia.
- Avoid polypharmacy if possible. Request local pharmacy review of medications. Discuss use of drugs to be avoided in elderly with Physician (such as Elavil, Limbitrol, Triavil, Catapres, Flexeril, Soma, Valium, Estrogens, Levsin, Procardia, Adalat, Phenergan, Darvon, Darvocet, Tagamet, Benedryl. Refer to http://www.OFMQ.org.
- Optimize sensory input. Maximize community and socio-economic supports. Correct hearing impairments as able. Address vision problems with eye exams and corrective measures
- Improve nutrition and correct malnutrition: need for regular protein, balance of nutrients, enhanced tastes of foods, hydration. Address oral problems with dental exam and corrective measures. Reduce frequency of eating alone. Address medication side effects to diet as able. Address bowel regularity.
- Mobilize
    - Assess for fall risk such as "Get Up and Go" ; address fall risks, balance, gait; Instruct in safe transfers; Ensure adequate physical support is provided as necessary during activity to prevent injury and alley fear of falling
    - Minimize muscle wasting- assist with simple exercise, encourage Consistent walking and self care as able----- Bed is BAD
    - Evaluate for aids/adaptations such as foot wear, walking aides, chairs, bed, lighting, floors, mats, bathing equipment, surface heights, ramps, rails, lighting, etc.

Guidelines for Documentation

Specifics:

Review the Documentation Specifics Chart and sample progress note entries.

Documentation (for the record):
Objective/Subjective Documentation

Objective Documentation: Writing down the observable (measureable) actions of a member without commenting on your personal opinions. Objective charging provides consistent, accurate and factual information and is the kind of writing that is needed in health/service records.

a. Record Who, what, Where, and How information. Words must "paint a picture" or "tell a story" that describes the who, what, when, where and how of the situation being written.
b. Record using the five senses: "I saw…", "heard…", "She looked …...", "He said…...", "It felt like…...".
Record items/descriptions that any and everyone involved with the member can observe and measure.

Subjective Documentation: Writing down your judgments and/or feelings (personal opinions) about the events and circumstances in which you find the member. Subjective documentation is unreliable, and is not legal evident, since it is not based on fact, but could be different based on a different person observing (and reacting to) the situation.

a. Do not record how you felt about the situation or how you think the member felt (or "should have" felt or responded) in the situation.
Do not record items that cannot be measure or observed.

DON'T Record:		**DO Record:**
Subjective Opinions:		*Objective Facts:*
* He was angry		* He yelled, "I'm mad at your!" * She
* She appeared depressed		cried throughout our visit
* There was a big, ugly bruise		* The bruise was maroon-colored, about the size of a silver dollar.
* The house was filthy		* Rodent droppings along baseboard & a smell of ammonia.
* She was acting crazy		* she was mumbling & pacing. About every 5 steps, she screamed "Zebra!"

Documenting Exceptions / Abnormal Situations:

Always record what is not normal for the member

Use facts and objective observations
If it is ABNORMAL - DOCUMENT the ABNORMALITY
If it is NOT written down as abnormal, it is considered normal for that member.
Describe beginning-to-end of an abnormal situation (what took the individual form "normal" to abnormal and back to "normal") so it is clear to the reader the condition was addressed and re-solved.

Timely Charting

1. If you don't have immediate access to the record, TAKE NOTES.
2. Record the description of the event as soon as possible after it happens for accuracy and timely record keeping and to prevent errors due to late or delayed charting entries.
3. For seizures, injuries or acute illnesses, records must be updated/completed before the individual goes to the doctor, clinic or hospital.

Timely documentation helps eliminate "late entries" to the record. A late entry can be made on occasion, if entered as such, but is not a good practice.

The Record as Legal Document

A. The clinical record is the "proof" of all care and services provided to the member**. IF IT WASN'T CHARTED, IT WASN'T DONE.**

B. Entries in the record must meet legal requirements.

C. A major purpose of documentation is to be the permanent record, and is therefore also useful for accreditation requirements.

Entries

Each entry to the record (including information written in error) must be:

Legible. (IF IT CAN'T BE READ, IT WASN'T DONE.) Dated. (Complete month/day/year). Timed (Hours/Minutes, am or pm).
Signed (Name and Title) on all forms in the record.
Written in blue or black ink (no pencil).
Based on objective data (facts, not opinions).
Documented in as timely a period as possible. It is essential to the continuity of the member's care since information is shared between the disciplines involved with the member's training, care and treatment.

Each entry must maintain confidentiality when documenting actions between two individuals.

DO NOT:

- Back date, tamper with, or add to notes previously written
- Document for anyone else or correct a colleague's errors
- Scribble or use "white-out"
- "Point the finger" at others in progress note entries

DO:

- Think about what you want to say before you record it
- Stick to the facts
- Be brief, but complete - give the next reader an accurate picture

Correcting Errors

Error corrections must be:

- Legible (must be able to read error)
- Dated (if correction made at a later date than original entry was made)
- Drawn through with a single line
- Initialed by the person making and correcting the error

A. Only the person who made the erred entry can correct it.
REPEAT: DO not scribble or use white-out

Documenting a Late Entry

A. Late entries allow documentation to be added to the record and keep entries in chronological order. (Entries must be in chronological order to be located and legal.)
Record the actual date the late entry is being made, and then refer to the day it should have been made in the note. (Dates noted are very important to complete the "picture" painted by the progress notes.)

Terminology/Abbreviations

A. Use proper terms. Documentation must be written in a professional way.
Use only approved abbreviations which communicate a uniform, standardized meaning. Omit abbreviations that may be interpreted incorrectly. Refer to :
http://www.medilexicon.com/medicalabbreviations.php

B. If you do not know the proper terms or have access to acceptable references, use descriptive words that a reasonable person could understand:

- The size of an orange
- The color of straw
- It felt like sandpaper
- The sound of rain on a tin roof

DO NOT use "pet" or "nick names" for body parts/functions in clinical records, unless quoting someone.

Reasons for Good Documentation/Record Keeping

Payment Justification. The record is the basis for payment for services received by a member. Parts of the record may be reviewed by, or submitted to, the organization(s) or individual(s) that are the member's source(s) of funding for those services

Legal Documentation. The record can be used as evidence in a court of law, unless the member objects. The record (the documents) belongs to the provider agency, but the information is the member's. Any provider's Consumer (Member) Bill of Rights must assure each individual (or his/her legal agent) the right to review his/her own records, and should state the agency policies and procedures for access to the record and/or obtaining copies of the documentation within it.

Quality Management. The record is used to measure whether the individual is receiving the type of care the agencies agreed to provide and whether that care is moving the individual toward the expected out-comes in the service plan.

Planning Individualized Care. All members of the service team can use the records, collectively, to evaluate progress and plan additions and/or changes in the individual's service plan. If the historical view is created well, we can identify changes or trends in the member's health, compliance with the plan, or need for additional services.

Communication. By keeping accurate and complete records we can share information with other direct caregivers, the individual's case manager and health care professionals. Because we may not be there when the next service provider sees the member, we can explain what we did and how the individual was at our last visit. Plus, we create an historical view of the individual's progress/situation.

Statistics. Information is collected from groups of records to assist in assessing service needs in a community and making the necessary plans to provide necessary care.